2825 W. A.J. Hwy. Morristown, TN 37814
Phone: 423-307-5757

6900 Lenox Village Dr., Ste #14 Nashville, TN 37211
Phone: 615-864-8990

FountainRx

Osteoporosis

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

Patient Information:

Name:_____
Address:_____
City:_____ State:___ Zip_____
Phone:_____ Alt Phone:_____
Email:_____
DOB:_____ Height/Weight: _____
Gender: ☐ M ☐ F Caregiver:_____

Prescriber Information:

Name:_____
Address:_____
City:_____ State:___ Zip:_____
Phone:_____ Fax:_____
NPI:_____ DEA:_____
Tax ID:_____
Office Contact:_____ Phone:

CLINICAL INFORMATION:

Diagnosis: ☐ **M81.0 Osteoporosis - age-related/post-menopausal** ☐ **M83.5 Osteoporosis - drug-induced** ☐ **M81.80 Osteoporosis – unspecified** ☐ **Other: (ICD-10):**_____

T-Score Result:_____ **Fracture Site:**_____

Drug Allergies:_____

Contraindications: ☐ **GERD** ☐ **Other:**_____

Prior Failed Medications: ☐ **Alendronate (Fosamax®)** ☐ **Risedronate (Actonel®)** ☐ **Ibandronate (Boniva®)** ☐ **Other:**_____

PLEASE FAX COPIES: ☐ **Medical Card (Front and Back)** ☐ **Prescription Card (Front and Back)** ☐ **Clinical Notes**

Medication	Dosage and Strength	Directions	Quantity	Refills
☐ **Forteo®**	☐ 600ug/2.4ml Pen ☐ 31 Gauge 5mm Needles	Inject 20ug (0.08ml) SC once daily. Discard device 28 days after first use. Use as directed with pen(s).	1 100	
☐ **Teriparatide**	☐ 620ug/2.48ml Pen ☐ 31 Gauge 5mm Needles	Inject 20ug (0.08ml) SC once daily. Discard device 28 days after first use. Use as directed with pen(s).	1 100	
☐ **Prolia®**	☐ 60mg/ml PFS	Inject 60mg (1ml) SC once every 6 months.	1	
☐ **Reclast®**	☐ 5mg/100ml Vial	☐ Infuse 5mg (100ml) every year. ☐ Infuse 5mg (100ml) every 2 years.	1	
☐ **Evenity®**	☐ 105mg/1.17 ml PFS	Inject 210mg SC once monthly	1	
☐ **Other**	☐ _____	☐ _____		

By signing this form and utilizing our services, you are authorizing FountainRx or its designee to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. Generic substitution is permissible as provided by law. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature:_____ **Date:**_____