

Osteoporosis

Four simple steps to submit your referral.

1 PATIENT INFORMATION

New patient Current

Patient first name _____
 Last name _____ Middle initial _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____ Work phone _____
 Cell phone _____ Evening phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
 Insured's name _____
 Insured's employer _____
 Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____
 Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's name and title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office Patient's home Clinic
 Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 EXPECTED DATE OF FIRST/NEXT INJECTION _____
 DATE OF LAST INJECTION (if applicable) _____
 Agency nurse to visit home for injection? No Yes
 Agency name and phone _____
 Date labs obtained _____ Calcium _____
 Albumin _____ Vitamin D _____
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Evenity® (romosozumab-aqqg)	Two-pack carton of 105 mg/1.17 mL prefilled syringes. Total dose 210 mg	Inject 210 mg (two 105 mg syringes sequentially) subcutaneously once every month for 12 doses in the abdomen, thigh or upper arm. Note: Evenity must be administered by a healthcare provider.	Dispense: <input type="checkbox"/> 1 carton (2 syringes) <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Forteo® (teriparatide [rDNA origin])	Multi-dose prefilled Forteo delivery device containing 28 daily doses of 20 mcg	Inject 20 mcg subcutaneously once daily Stop date _____ Cumulative use parathyroid hormone analogs (e.g. teriparatide and abaloparatide) for more than 2 years during a patient's lifetime is not recommended.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills _____
<input type="checkbox"/> Prolia® (denosumab)	60 mg/1 mL prefilled syringe	Administer 60 mg every 6 months as a subcutaneous injection in the upper arm, upper thigh or abdomen. Note: Prolia must be administered by a healthcare provider.	Dispense: <input type="checkbox"/> 1 syringe <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Tymlos® (abaloparatide)	Multi-dose prefilled Tymlos pen delivering 30 daily doses containing 80 mcg of abaloparatide	Inject 80 mcg subcutaneously once daily Stop date _____ Cumulative use parathyroid hormone analogs (e.g. teriparatide and abaloparatide) for more than 2 years during a patient's lifetime is not recommended.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills _____
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Osteoporosis team at 888.302.1028. To reach your team, call toll-free 888.608.9010.

You can now track shipments for all your Accredo patients. Go to <https://prescribers.accredo.com> and click "Help" to register.

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