Prescription & Enrollment Form

Osteoporosis

accredo®

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
❑ 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: ❑ 1 carton (2 syringes) ❑ Other _____ Refills _____
❑ 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: ❑ 1-month supply ❑ 3-month supply Refills _____
❑ 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: ❑ 1 syringe ❑ Other _____ Refills _____
❑ 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: ❑ 1-month supply ❑ 3-month supply Refills _____
❑ 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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