TODT HILL PHARMACY
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OSTEOPOROSIS ENROLLMENT

Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Office:	**Fax:**
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F DOB: _____/_____/_____	SS#: _____-_____-_____
Tel: Alt Tel:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____
Street:	City: State:	ZIP:

MEDICAL INFORMATION

Prior Failed Medication(s):	Length of Treatment:	Reason for Discontinuing:
Actonel	_____/_____/_____-_____/_____/_____	
Boniva	_____/_____/_____-_____/_____/_____	
Fosamax	_____/_____/_____-_____/_____/_____	
Prolia	_____/_____/_____-_____/_____/_____	
Reclast	_____/_____/_____-_____/_____/_____	

☐ Patient has not tried or failed any prior medication(s).

Diagnosis Date:_____/_____/_____
- ☐ M80.0 Age Related Osteoporosis with Fracture
- ☐ M80.8 Other Osteoporosis with Fracture
- ☐ M81.0 Age Related Osteoporosis without Fracture (Senile/Postmenopausal)
- ☐ M81.6 Localized Osteoporosis
- ☐ M81.8 Other Osteoporosis without Fracture
- ☐ M85.9 Disorder of Bone Density and Structure, Unspecified (Osteopenia)
- ☐ M89.9 Disorders of Bone, Unspecified
- ☐ M84.48XA to M84.40XA Pathological Fracture, Unspecified Site

☐ Other: _____

Lowest Dexa T-score: _____ Site: _____ Date: _____/_____/_____

Fracture Site(s): _____ Date: _____/_____/_____

Allergies:

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

PRESCRIPTION

☐ New ☐ Refill | Ship By: _____/_____/_____ | SHIP TO: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug		Directions	Quantity	Refills
Boniva®	☐ Pre-Filled Syringe	☐ Inject 3mg IV over 15-30 seconds every 3 months	3mg/3ml (1 syringe)	
Forteo®	☐ Pen	Inject 20mcg SQ Daily	600mcg/2.4ml (1 pen)	
		☐ Pen Needles: Use with Forteo daily as directed.	30 days supply	
Prolia®	☐ Pre-Filled Syringe	☐ Inject 60mg SQ once every 6 months	60mg/ml (1 syringe)	
Reclast® (Zoledronic Acid)	☐ Vial	☐ Infuse 5mg IV, over no less than 15 minutes, every year ☐ Infuse 5mg IV, over no less than 15 minutes, every two years	1 vial	
Tymlos®	☐ Pre-Filled Syringe	☐ Inject 80mg SQ daily	30 doses	

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ TODT Hill to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing TODT Hill Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations

Prescribing Practitioner: **Date:** _____/_____/_____

CONFIDENTIALITY NOTICE