

### PATIENT DEMOGRAPHICS:

|  |                      |
|--|----------------------|
| PATIENT NAME:  | PREFERRED CONTACT #: |
| DATE OF REFERRAL:  | SECONDARY CONTACT #: |
| SOCIAL SECURITY NUMBER:  | ADDRESS:             |
| DATE OF BIRTH: GENDER: <input type="checkbox"/> F <input type="checkbox"/> M | CITY, STATE, ZIP:    |







### PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-10 CODE

- M81.0 - Generalized Osteoporosis     
  M81.0 - Postmenopausal Osteoporosis     
  M81.8 - Idiopathic Osteoporosis  
 M81.8 - NEC Osteoporosis     
  Other: \_\_\_\_\_

### REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

1. INSURANCE CARD (Front & Back)   
  2. PATIENT DEMOGRAPHICS   
  3. MOST RECENT LABS   
  4. H & P

### MEDICATION SELECTION:

|  |   |                |
|--|---|----------------|
| <br><b>Boniva</b><br>ibandronate sodium                              | <input type="checkbox"/> INJECT 3MG IV PUSH EVERY 3 MONTHS  | REFILLS: _____ |
| <br><b>EVENITY</b><br>(romosozumab-aqqg)<br>injection 105 mg/1.17 mL | <input type="checkbox"/> INJECT 210 MG SC ONCE MONTHLY FOR 12 MONTHS                                  | REFILLS: _____ |
| <br><b>Reclast</b><br>(zoledronic acid)                            | <input type="checkbox"/> INFUSE 5 MG IV OVER 15-20 MINUTES ANNUALLY                                   | REFILLS: _____ |
| <br><b>FORTEO</b><br>teriparatide (rDNA origin) injection          | <input type="checkbox"/> INJECT 20 MCG SC, AS DIRECTED, DAILY   | REFILLS: _____ |
| <br><b>prolia</b><br>denosumab                                     | <input type="checkbox"/> INJECT 60 MG SC ONCE EVERY 6 MONTHS  | REFILLS: _____ |
| <br><b>TYMLOS</b><br>(abaloparatide) injection                     | <input type="checkbox"/> INJECT 80 MG SC ONCE DAILY IN PERIUMBILICAL REGION                           | REFILLS: _____ |
| <b>PEN NEEDLES</b>   | <input type="checkbox"/> 30 GAUGE <input type="checkbox"/> 31 GAUGE <input type="checkbox"/> 32 GAUGE |                |

### PRESCRIBER INFORMATION:

|                      |            |
|----------------------|------------|
| PHYSICIAN NAME:      | PHONE:     |
| OFFICE CONTACT:      | FAX:       |
| ADDRESS:             | LICENSE #: |
| CITY, STATE, ZIP:    | NPI:       |
| PHYSICIAN SIGNATURE: | DATE:      |