

YourC ommun ityRx.com

# FAX: 844-524-HOPE (4673)

Phone: 844-690-4462

OSTEOPOROSIS

3922B Willis Ave. Louisville, KY 40207

## Need By Date: / / SHIP TO: 0 Office O Other

PATIENT INFO PROVIDER INFO

## Pharmacy to Inject 0

Name: Name: Address: Address: City: State: Zip: City: State: Zip: Phone: Alt. Phone Phone: Fax Social Security# DOB: NPI: DEA: Height: Weight: License # Alternate Contact: Phone Contact Person: Sp #

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

|  |
| --- |
| CLINICAL INFORMATION |
| Diagnosis: 0 M81.0 Osteoporosis |  | O Other:  | 0 | ICD-10: |  |  |
| Patient Weight | Patient Height |  | T-Score Result | Location |
| Patient Allergies |
| Fracture History |
| Other Notes: |
| Follow Up With Prescriber: 0 3 Months | 0 | 6 Months 0 9 Months 0 12 Months |  |  |  |  |
| FAILED PRIOR MEDICATIONS |  |  |  |  | DISCONTINUATION REASON |  |
|  |  |
|  |  |

EI Forteo

Ej Profia EI Tymlos EI Reclast

(ZOle drOme Acid)

600ug/2.4m L Pen 60mg/mL Pen 312oug/1.56mL Pen 5 mg

Inject 20ug (0.08mL) subcutaneously once daily

Inject 60mg (1mL) subcutaneously once every 6 MONTHS Inject 80ug (0.04mL) subcutaneously once daily

@ Infuse 5 mg every year

0 Infuse 5 mg every 2 years

EI Pen Needles 31 Gauge Smm Use as directed with pens

Ej Other Take one tablet PO QD with or without food

I authorize the pharmacy to act as an agent to obtain prior authorization for the prescribed medications. We will also pursue available copay and fnancial assistance on behalf of your patients. If PA Denied: Draft Appeal Automatically for Review

Today's Date: / /

Prescriber Signature: Dispense as WriLen (DAW)

Important Notice: This fax is intended only to be named the addresse and contains information that may be protected health information under federal and state laws. If you are nottheinendedred$en do notcopy, dstJb2eordessiminae pease noWythesenderimmedaejanddestoytWsdocvment

Revised 2/15/a 9