Osteoporosis

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient information

Patient Name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
1˚ Language: _____ Wt:_____ ❑kg ❑lbs Ht:_____❑cm ❑in
Address: _____
Apt/Suite: _____ City:_____ State:_____ Zip:_____
Phone:_____ Alternate Phone:_____
Caregiver name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____
Insurance Plan: _____ Plan ID # _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name:_____
NPI #: _____
Address: _____
Apt/Suite #_____ City:_____ State:_____ Zip:_____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email address_____
If shipping to prescriber:❑ 1st Fill ❑ Always ❑ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis ICD-10:

❑ M80.0 **Age-related** osteoporosis **with** fracture ❑ M80.8 **Other** osteoporosis **with** fracture ❑ M81.0 **Age-related** osteoporosis **without** fracture
❑ M81.6 Localized Osteoporosis ❑ M81.8 **Other** osteoporosis **without** fracture ❑ M85.9 Bone density and structure disorders
❑ M88.0 – M88.9 Paget's Disease ❑ M89.9 Disorder of bone, unspecified ❑ M94.9 Disorder of cartilage, unspecified
❑ Other: _____

BMD/T-Score(s): _____ Location(s): _____ Date: _____ New therapy for patient? ❑ Yes ❑ No
Osteoportic fracture – Date(s): _____ Location(s):_____ _____ ❑ None High risk patient? ❑ Yes ❑ No
Risk factor(s) Information: _____ Any prior treatment: ❑ No ❑ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription

❑ Boniva®	❑ Inject the contents of 1 PFS intravenously every 3 months. To be administered by a healthcare professional. Qty: ❑ 1 PFS (3 mg/3 mL) Refills: _____
❑ Forteo®	❑ Inject 20 mcg SQ once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles. Qty: 30 Needles per 1 Pen (600 mcg/2.4 mL) ❑ 1 Pen with 30 Needles ❑ 3 Pens with 90 Needles Refills: _____
❑ Prolia®	❑ Inject contents of 1 PFS SQ every 6 months. Qty: ❑ 1 PFS (60 mg/1 mL) Refills: _____
❑ Reclast®	❑ Infuse 5 mg intravenously over no less than 15 minutes once annually. Qty: ❑ 1 Vial (5 mg/100 mL) Refills: _____

Injection Training Provided By: ❑ Physician's office ❑ Pharmacy ❑ Other: _____

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.