

OSTEOPOROSIS PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

altScripts Specialty Pharmacy
 1636 Miller Park Way, West Milwaukee, WI 53214
 Phone: 414-385-9500 Fax: 414-385-7200
 www.altscripts.com



Patient Information: please provide a copy of the patient's insurance card or information					
Patient Name:		DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:
Address:		City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:	ID#:	Group #:		
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:					
Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization					
Diagnosis / ICD-10: <input type="checkbox"/> M80.0 Age-related osteoporosis with fracture <input type="checkbox"/> M80.8 Other osteoporosis with fracture <input type="checkbox"/> M81.0 Age-related osteoporosis without fracture <input type="checkbox"/> M81.6 Localized osteoporosis <input type="checkbox"/> M81.8 Other osteoporosis without fracture <input type="checkbox"/> M85.9 Bone density and structure disorders <input type="checkbox"/> M88.0 - M88.9 Paget's Disease <input type="checkbox"/> M89.9 Disorder of bone, unspecified <input type="checkbox"/> M94.9 Disorder of cartilage, unspecified <input type="checkbox"/> Other: _____					
BMD/T Score(s):	Location(s):	Date:	New therapy for patient: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Osteoporotic fracture - Date(s):	Location(s):	<input type="checkbox"/> None	High risk patient: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Risk factor(s) information:					
Prior treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No List therapy, start/end dates:					
Comorbidities:			Concomitant Medications:		
Injection Training Provided By: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other:					
Medication	Quantity / Strength	Directions	Refills		
<input type="checkbox"/> Boniva®	<input type="checkbox"/> 1 prefilled syringe (3 mg /3 mL)	<input type="checkbox"/> Inject the contents of 1 PFS intravenously over 15-30 seconds every 3 months. To be administered by a healthcare professional.			
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 1 pen (600 mcg/2.4 mL) with 30 needles <input type="checkbox"/> 3 pens with 90 needles	<input type="checkbox"/> Inject 20 mcg SQ once daily. Dispensed with BD Mini Pen Needles.			
<input type="checkbox"/> Prolia®	<input type="checkbox"/> 1 prefilled syringe (60 mg /1 mL)	<input type="checkbox"/> Inject 60 mg SQ every 6 months in the upper arm, upper thigh or abdomen. To be administered by a healthcare professional.			
<input type="checkbox"/> Reclast®	<input type="checkbox"/> 1 vial (5 mg /100 mL)	Infusion given intravenously over no less than 15 minutes: <input type="checkbox"/> Osteoporosis: 5 mg once a year <input type="checkbox"/> Prevention of postmenopausal osteoporosis: 5 mg once every 2 years <input type="checkbox"/> Paget's disease of bone: a single 5 mg infusion			
<input type="checkbox"/> Tymlos™	<input type="checkbox"/> 1 prefilled pen (30 daily doses of 80 mcg /40 mL)	<input type="checkbox"/> Inject 80 mcg subcutaneously once daily			
Physician Information					
Prescriber name:		Phone:	Office contact name:		
Prescriber address:		City:	State:	Zip:	
NPI:	DEA:	Fax and/or Email:			
Prescriber signature:		Date:	<input type="checkbox"/> DO NOT SUBSTITUTE		

Important Notice: This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.