ABD Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

OSTEOPOROSIS ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female
Address:
Phone: Alternate Phone:
Height: Weight: Insurance Information: ☐ Attached
Allergies:

DIAGNOSIS

☐ Osteoporosis, unspecified (M81.0) ☐ Senile osteoporosis (M81.0) ☐ Idiopathic osteoporosis (M81.8)
☐ Disuse osteoporosis (M81.8) ☐ Other osteoporosis (M81.8) ☐ Long-term (current) use of steroids (Z79.52)
☐ Other: ____

CLINICAL INFORMATION

BMT/T-score: __________________ Date of T-score: ____________
Is patient new to therapy? ☐ Yes ☐ No
History of osteoporatic fracture? ☐ Yes ☐ No
If no, is patient at high risk? ☐ Yes ☐ No
If yes, date of fracture: _____________ Location of fracture: ____

FAILED THERAPIES

☐ Fosamax ☐ Actonel ☐ Forteo ☐ Prolia ☐ Reclast ☐ Boniva ☐ Other: ______________ Dates: ____________________

DRUG	DIRECTIONS	QTY	REFILLS
□ **Tymlos 3120 mcg/1.56ml pen**	□ Inject 1 dose (80 mcg) SQ daily Date initiated:____/____/____ (max: 2 years) *dispense with pen needles*	□ 1 pen (4 weeks) □ 3 pens (12 weeks)	
□ **Boniva 3 mg/3 mL PFS**	□ Inject the contents of 1 vial (3 mg) intravenously every three months (To be administered by a healthcare professional)	□ 1 prefilled syringe	
□ **Evenity 105mg/1.17 mL PFS**	□ Inject 205 mg (two 105 mg prefilled syringes) SQ once monthly (max: 1 year)	□ 2 prefilled syringes	
□ **Forteo 600 mcg/2.4 mL pen**	□ Inject 1 dose (20 mcg) subcutaneously daily Discard device 28 days after first use Date initiated:____/____/____ (max: 2 years) *dispense with pen needles*	□ 1 pen (4 weeks) □ 3 pens (12 weeks)	
□ **Prolia 60 mg/1mL PFS**	□ Inject the contents of 1 syringe (60 mg) subcutaneously every six months	□ 1 prefilled syringe	
□ **Reclast 5 mg/100 mL vial**	□ Infuse 5 mg intravenously over no less than 15 minutes once annually	□ 1 vial	
□ **Other:**			

☐ Patient is ready to start treatment, contact patient for delivery ☐ Ship all orders to office ☐ Ship first order to office, subsequent orders to patient

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

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified