Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

OSTEOPOROSIS ENROLLMENT FORM

Today's Date: ______________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**____________ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No

All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ______________ ☐ Male ☐ Female DOB: ______________
Patient's First Name: ______________ Patient's Last Name: ______________
Address: ______________ City: ______________ State: ______ ZIP: ______
Best Phone Number: ______________ Alternate Phone Number: ______________
Height:__________ Weight: __________ ☐ kgs. or ☐ lbs. Recorded Date: ______________
Caregiver: ______________ Allergies: ______________
Emergency Contact Name: ______________ Emergency Contact Phone #: ______________

Insurance Information: Please fax copy of insurance card (front + back)

Clinical Information

Diagnosis/ICD-10 ______________

☐ Osteoporosis, Unspecified
☐ Senile Osteoporosis
☐ Idiopathic Osteoporosis
☐ Disuse Osteoporosis
☐ Other Osteoporosis
☐ Long-term (current) use of Steroids
☐ Other: ______________

Date of Diagnosis:______________
BMD/T-Score:______________
Is patient new to therapy? ☐ Yes ☐ No
History of osteoporotic fracture? ☐ Yes ☐ No
If no, is patient at high risk? ☐ Yes ☐ No
If yes, date of fracture:______________
Location of fracture:______________

Prior (FAILED) Therapy:

Therapy	Date(s)
☐ **Fosamax**	
☐ **Actonel**	
☐ **Forteo**	
☐ **Prolia**	
☐ **Reclast**	
☐ **Boniva**	
☐ **Other (please list):**______________	

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ FORTEO®	☐ 600mcg/2.4mL. Pen	☐ Inject 1 dose (20mcg) subcutaneously once daily. Discard device 28 days after first use.	☐ 1 pen *(4-week supply)* ☐ 3 pens *(12-week supply)*	______
☐ BD® MINI PEN NEEDLES	☐ 31G x 3/16"	☐ Use with Forteo® pen once daily as directed	☐ #90 pen needles ☐ #30 pen needles	______
☐ PROLIA®	☐ 60mg/1mL. PFS	☐ Inject the contents of 1 syringe (60mg) subcutaneously every 6 months	1 prefilled syringe	______
☐ RECLAST®	☐ 5mg/100mL. vial	☐ Infuse 5mg intravenously over no less than 15 minutes once annually	One: 5mg/100ml vial	___0___
☐ BONIVA®	☐ 3mg/3mL. PFS	☐ Inject the contents of 1 syringe (3 mg) intravenously every 3 months. To be administered by a healthcare professional.	One: 3mg/3ml PFS	______
☐ TYMLOS®	☐ 3120 mcg/1.56ml	☐ Inject 1 dose (80 mcg) subcutaneously once daily	1 pen (4 week supply) 3 pen (12 week supply)	______

Forteo® Injection Training

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training
☐ Giant Eagle to coordinate injection training

Prescriber Information

Date Prescription Needed: ______________
Physician Name (please print): ______________ Contact Name: ______________
Phone #: ______________ Fax #:______________ NPI #: ______________
Office Address: ______________ City: ______________ State: ______ ZIP: ______
State License #: ______________ DEA #: ______________

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.

____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: ______________ **Date:** ______________