



Osteoporosis Patient Enrollment and Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447 ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

PATIENT INFORMATION

Patient Name _____
 DOB ___/___/___ SSN _____ Gender _____
 Weight _____ Height _____ Phone _____
 Address _____
 City, State, Zip _____
 Cell Phone _____ E-Mail _____
PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM
 Insurance Co. Name _____
 Insurance Co. Phone _____ Group# _____
 Policy Holder Name _____
 Policy Holder Employer _____
 Relationship to Patient _____
 ID# _____ RxBIN _____ PCN _____

PRESCRIBER INFORMATION

Prescriber's Name _____
 Practice Name _____
 DEA _____ NPI _____
 Address _____
 City, State, Zip _____
 Phone _____ Fax _____
 Office Contact Person _____
 Office Contact EMAIL _____
 Prescription Date _____ Date Needed _____
 Ship to: Patient Prescriber's Office Discount Drug Mart

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.
Prescriber Signature _____

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis _____ Date of Diagnosis _____
 ICD-10 Code: _____
 Is there a History of fractures? YES NO Lowest DEXA T-Score: _____
 Other risk factors for osteoporotic fracture: _____
 Drug Allergies _____ Latex Allergy? YES NO
 Prior Osteoporosis Therapy and for how long? _____
 Reason for Discontinuation? _____
 Any other relevant medical info? _____

PRESCRIPTION INFORMATION (DAW requests must be handwritten)

Boniva® (ibandronate) 3 mg/ 3 ml Prefilled Syringe KIT
 Directions: Inject 3mg IV over 15-30 seconds every 3 months Qty _____ Refills _____

Forteo® (teriparatide) 2.4ml Prefilled Pen
 Directions: Inject 20mcg subcutaneously once daily as directed Qty _____ Refills _____

Prolia® (denosumab) 60mg Prefilled Syringe
 Directions: Inject 60mg subcutaneously every 6 months Qty _____ Refills _____

Reclast® (zoledronic acid) 5mg in a 100 mL ready to infuse solution bottle
 Directions: _____ Qty _____

Tymlos™ (abaloparatide) 1.56 mL Prefilled Pen
 Directions: Inject 80mcg subcutaneously once daily as directed Qty _____ Refills _____

ADDITIONAL SUPPORTIVE MEDICATION

Medication Name and Dosage Form	Strength	Directions	Qty	Refills

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.