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 _____

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 _____

Ship to: ☐Patient ☐Prescriber's Office ☐Discount Drug Mart

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 _____

☐ **Evenity® (romosozumab)** ☐ 105mg Prefilled Syringe

Directions: Administer 210 mg subcutaneously once every month 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 _____