WELLPARTNER PHARMACY | OSTEOPOROSIS ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ M81.Ø Age-related osteoporosis w/o fracture
◯ M8Ø.Ø Age-related osteoporosis w/ fracture
◯ M81.8 Other osteoporosis w/o fracture
◯ M8Ø.8 Other osteoporosis w/ fracture
◯ Other:

Height (in/cm): Weight (lb/kg):

Allergies:

Current Medications:

Does the patient have a history of osteoporotic fracture? ◯ Yes ◯ No

Has patient failed or is unable to tolerate other previous osteoporosis therapy? ◯ Yes ◯ No
If yes, please explain:

Does the patient have more than one risk factor for fracture? ◯ Yes ◯ No
If yes, please explain:

Will the patient be taking Forteo in combination with a bisphosphonate? ◯ Yes ◯ No

Has the patient received Forteo in the past? ◯ Yes ◯ No
If yes, have they received more than 24 months total therapy with Forteo? ◯ Yes ◯ No

Does the patient have any of the following contraindications to Forteo use:

◯ Paget's disease of the bone
◯ Prior radiation therapy involving the skeleton
◯ Metaboloic bone disease other than osteoporosis
◯ Bone metastases
◯ Pre-existing hypercalcemia
◯ Unexplained elevation of alkaline phosphatase
◯ History of skeletal malignancy
◯ Open epiphyses

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Boniva	3 mg/3 ml prefilled syringe	◯ Inject contents of one syringe (3mg) via IV once every 3 months ◯ Other:	◯ 1 syringe (3-month supply) ◯ Other:	
◯ Forteo	600 mcg/2.4 ml delivery device	Inject 20 mcg (0.08 ml) SQ once daily.	◯ 1 device (4-week supply) ◯ 3 devices (12-week supply)	
◯ Needles - 31 gauge ◯ 5 mm ◯ 6 mm ◯ 8 mm		Use with Forteo delivery device as directed.	◯ 4-week supply ◯ 12-week supply	
◯ Prolia	60 mg/1 ml prefilled syringe	◯ Inject 60 mg subcutaneously every 6 months. ◯ Other:		
◯ Reclast	5mg/100ml vial	Infuse 5mg IV once a year	1 vial	
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE