UnityPoint at Home

**SPECIALTY PHARMACY**
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

# OSTEOPOROSIS PRESCRIPTION AND REFERRAL FORM

## PATIENT INFORMATION

***Please fax a copy of ALL of patient's Prescription, Primary and Secondary insurance cards (both sides)***
***Also please include any other beneficial information for prior authorization and dispensing assessments.***

**Patient Name** ______________________________ **DOB** ______________ ☐ Male ☐ Female

**Address**______________________________ **City**______________ **State** ____________ **Zip** __________

**Home Phone** ________________ **Cell Phone** ________________ **Work phone** ________________ **Email** ________________

**Primary Language** ☐ English ☐ Spanish ☐ Other: specify ________________ **Allergies** ______________________________

**RX Member ID** ________________ **RX Group ID** ________________ **RX PCN** ______________ **RX BIN**________________

## CLINICAL INFORMATION / PATIENT HISTORY

**PLEASE SUBMIT SUPPORTING DOCUMENTATION**

| Height: | Weight: | Date of Next injection: ___/___/___ | Date of last injection (if applicable): ___/___/___ |
|---|---|---|---|

Diagnosis / Primary ICD-10 Code:

Date of labs obtained: ____/_____/_____ Calcium: Albumin: Vitamin D: BMD: T Score:

Current Medication List:

Other relevant details:

## PRESCRIPTION

☐ **NEW PRESCRIPTION** ☐ **REAUTHORIZATION** ☐ **RESTART THERAPY**

**DELIVER TO:** ☐ **PROVIDER OFFICE** ☐ **PATIENT HOME** ☐ **OTHER CLINIC:** ________________

☐ **Forteo®** (Teriparatide [rDNA origin]) – ☒ Multi-dose prefilled Forteo delivery device containing 28 daily doses of 20 mcg

Sig: ☒ Inject 20 mcg subcutaneously once daily
Dispense: ☐ One month supply
☐ Three month supply

Refills: # ____ (one year / 12 refills)
Stop Date*: ______________________________

*Note: Cumulative use parathyroid hormone analogs (e.g. teriparatide and abaloparatide) for more than 2 years during a patient's lifetime is not recommended

☐ **Prolia®** (Denosumab) – ☒ 60 mg / 1 mL prefilled syringe

Sig: ☒ Administer 60 mg every 6 months subcutaneously in the upper arm, upper thigh, or abdomen*
Dispense: ☐ One month supply
☐ Three month supply

Refills: # ____ (one year / 2 refills)

*Note: Prolia must be administered by a healthcare professional

☐ **Tymlos™** (Abaloparatide) – ☒ Multi-dose prefilled Tymlos™ pen delivering 30 daily doses containing 80 mcg of abaloparatide

Sig: ☒ Inject 80 mcg subcutaneously once daily*
Dispense: ☐ One month supply
☐ Three month supply

Refills: # ____ (one year / 11 refills)
Stop Date*: ______________________________

*Note: Cumulative use parathyroid hormone analogs (e.g. teriparatide and abaloparatide) for more than 2 years during a patient's lifetime is not recommended

☐ Dispense all supplies needed to administer medication as needed for administration. Send quantity sufficient for medication day supply.
☐ No supplies needed

☐ **Other / Additional Instructions** (as needed):

**BY SIGNING BELOW, I CERTIFY THAT THE ABOVE THERAPY IS MEDICALLY NECESSARY.**
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

| **Prescriber's Signature:** (No Stamps) | | **DATE:** | |
|---|---|---|---|

Print Prescriber's Name:______________________________ NPI: ________________ Phone________________

Address ______________________________City________________ State __________ Fax ________________