elixir
SPECIALTY PHARMACY

Osteoporosis Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer Name: _____
Date of Birth: _____ Sex: M☐or F☐Caregiver:_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of customer's prescription insurance card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Customer:_____
ID# _____Group#_____

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name:_____
Address:_____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#_____NPI#_____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____

Date Shipment Needed: _____
Ship to: ☐ Patient ☐ Prescriber ☐ Other:_____
Shipment Address: _____Attn: _____
City: _____State: _____Zip:_____
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis: ☐ M81.0 Age-related osteoporosis w/o fracture ☐ M80.0 Age-related osteoporosis w/ fracture ☐ M81.8 Other osteoporosis w/o fracture ☐ M80.80 Other osteoporosis w/fracture
☐ Other: _ _ . _ _ _ Description: _____
History of fracture: ☐ Yes ☐ No Bone Density T-score: _____
Risk Factors Present: _____
Patients Allergies: _____
_____
Latex allergy: ☐ Yes ☐ No
Patient Weight: _____ lbs or kgs Patient Height: _____ cm or in Date: ____/____/_____

Medication History

Previous Medications	Duration of Use	Reason for Discontinuation

☐ **Boniva®** (ibandronate) 3mg IV bolus every 3 months
☐ **Evenity®** (romosozumab) 210 mg (2 injections) SC once every month
☐ **Forteo®** (teriparatide) Pen 20mcg SC once daily. Dispense with #100 pen needles
Injection training needed? ☐ Yes ☐ No ☐ In-office training scheduled
Anticipated date of first injection: ____/____/_____
☐ **Prolia®** (denosumab) 60mg SC every 6 months
☐ **Reclast®** (zoledronic Acid) 5mg IV once yearly
☐ **Tymlos®** (abaloparatide) Pen 80mcg SC once daily. Dispense with #100 pen needles
Injection training needed? ☐ Yes ☐ No ☐ In-office training scheduled
Anticipated date of first injection: ____/____/_____

Quantity Prescribed:☐QS 30 days or interval listed above ☐Other: _____
Refills Authorized:☐ 0 ☐1 ☐2 ☐3 ☐ 6 mos ☐1 yr ☐Other: _____

Date Shipment Needed: ____/____/_____ **Ship to: ☐ Patient ☐ Prescriber ☐ Infusion Clinic**
Shipment Address: _____Attn: _____
City: _____State: _____Zip:_____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X_____ ____/____/_____
Physician Signature (no stamps) **Date**
If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided: