

Customer Information
Customer Name: _____
Date of Birth: _____ Sex: M or F Caregiver: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
<small>Please attach copy of front and back of customer's prescription insurance card(s) if applicable</small>
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Customer: _____
ID# _____ Group# _____

Clinical Information and Prescription												
Diagnosis: <input type="checkbox"/> M81.0 Age-related osteoporosis w/o fracture <input type="checkbox"/> M80.0 Age-related osteoporosis w/ fracture <input type="checkbox"/> M81.8 Other osteoporosis w/o fracture <input type="checkbox"/> M80.80 Other osteoporosis w/fracture												
<input type="checkbox"/> Other: . . . Description: _____												
History of fracture: <input type="checkbox"/> Yes <input type="checkbox"/> No Bone Density T-score: _____												
Risk Factors Present: _____												
Patients Allergies: _____												
Latex allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No												
Patient Weight: _____ lbs or kgs Patient Height: _____ cm or in Date: ___/___/___												
<b>Medication History</b>												
<table border="1"> <thead> <tr> <th>Previous Medications</th> <th>Duration of Use</th> <th>Reason for Discontinuation</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Previous Medications	Duration of Use	Reason for Discontinuation									
Previous Medications	Duration of Use	Reason for Discontinuation										

Prescriber Information
Practice/ Organization Name: _____
Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
<b>Date Shipment Needed:</b> _____
<b>Ship to:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber <input type="checkbox"/> Other: _____
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip: _____
<small>If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.</small>

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

<b>Quantity Prescribed:</b> <input type="checkbox"/> QS 30 days or interval listed above <input type="checkbox"/> Other: _____
<b>Refills Authorized:</b> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 mos <input type="checkbox"/> 1 yr <input type="checkbox"/> Other: _____
<b>Date Shipment Needed:</b> ___/___/___ <b>Ship to:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber <input type="checkbox"/> Infusion Clinic
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip: _____
<small>If shipped to the physician's office, physician accepts on behalf of patient for administration in office.</small>
<b>X</b> _____ / ___/___
<b>Physician Signature (no stamps)</b> <span style="float:right"><b>Date</b></span>
<small>If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided:</small>

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.