OSTEOPOROSIS

Garden Grove, CA toll free 800.228.3643 toll free fax 866.539.1092
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO

Patient Name

Address

City, State, Zip

Main Phone Alternate Phone

Social Security #

Date of Birth ❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name

DEA # NPI # License #

Address

City, State, Zip

Phone Fax

Contact Person

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑ M81.0 Osteoporosis ❑ Other: _____ DX Code: _____

Drug Allergies: _____

Prior Failed Meds:

❑ alendronate (Fosamax®) Length of Treatment _____ ❑ Reason for Discontinuing _____

❑ ibandronate (Boniva®) Length of Treatment _____ ❑ Reason for Discontinuing _____

❑ risedronate (Atelvia®) Length of Treatment _____ ❑ Reason for Discontinuing _____

❑ prednisone/steroid Length of Treatment _____ ❑ Reason for Discontinuing _____

❑ _____ Length of Treatment _____ ❑ Reason for Discontinuing _____

Bone Density Test: T-Score _____ Type _____ Date _____

Fracture History: Site _____ Date _____ Site _____ Date _____

Has patient been on Forteo® before? ❑ Yes ❑ No If yes, how long? _____

Does patient have a latex allergy? ❑ Yes ❑ No

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Boniva®	3mg/mL Syringe	Infuse 3mg intravenously over 15 -30 seconds every 3 months	12 week supply (1 syringe)	_____
❑ Forteo®	2.4 mL Prefilled Multi Dose Pen	Inject 20mcg subcutaneously once a day	4 week supply (1 pen)	_____
❑ Prolia®	60mg/mL Syringe	Administer 60 mg every 6 months as a subcutaneous injection	24 week supply (1 syringe)	_____
❑ Reclast®	5mg/100mL solution	Infuse 5mg intravenously over 15 minutes once yearly	4 week supply (1 vial)	_____
❑ Tymlos®	1.56 mL Prefilled Multi Dose Pen	Inject 80mcg subcutaneously once a day	30 day supply (1 pen)	_____
❑ Other _____	_____	_____	_____	_____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date

Prescriber's Signature (no stamps) Dispense As Written Date

04897 06-05-2017 GGCA