OSTEOPOROSIS

Lake Mary, FL toll free _____ toll free fax _____

krogerspecialtypharmacy.com

Kroger 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 LMFL