



SPECIALTY PHARMACY

OSTEOPOROSIS

Orlando, FL toll free 855.274.1694 toll free fax 855.819.6922

krogerspecialtypharmacy.com

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

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	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:

<input type="checkbox"/> alendronate (Fosamax*)	Length of Treatment _____	<input type="checkbox"/> Reason for Discontinuing _____
<input type="checkbox"/> ibandronate (Boniva*)	Length of Treatment _____	<input type="checkbox"/> Reason for Discontinuing _____
<input type="checkbox"/> risedronate (Atelvia*)	Length of Treatment _____	<input type="checkbox"/> Reason for Discontinuing _____
<input type="checkbox"/> prednisone/steroid	Length of Treatment _____	<input type="checkbox"/> Reason for Discontinuing _____
<input type="checkbox"/> _____	Length of Treatment _____	<input type="checkbox"/> 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
<input type="checkbox"/> Boniva*	3mg/mL Syringe	Infuse 3mg intravenously over 15 -30 seconds every 3 months	12 week supply (1 syringe)	_____
<input type="checkbox"/> Forteo*	2.4 mL Prefilled Multi Dose Pen	Inject 20mcg subcutaneously once a day	4 week supply (1 pen)	_____
<input type="checkbox"/> Prolia*	60mg/mL Syringe	Administer 60 mg every 6 months as a subcutaneous injection	24 week supply (1 syringe)	_____
<input type="checkbox"/> Reclast*	5mg/100mL solution	Infuse 5mg intravenously over 15 minutes once yearly	4 week supply (1 vial)	_____
<input type="checkbox"/> Tymlos*	1.56 mL Prefilled Multi Dose Pen	Inject 80mcg subcutaneously once a day	30 day supply (1 pen)	_____
<input type="checkbox"/> 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
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