OSTEOPOROSIS

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192
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		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & 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 Pre Filled 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)	_____
❑ 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) Dispense As Written _____ Date _____

Prescriber's Signature (no stamps) Substitution Permitted _____ Date _____