



SPECIALTY PHARMACY

# OSTEOPOROSIS

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192

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	

**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:

<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 Pre Filled 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"/> 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

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

10-14-2016 NOLA