



Osteoporosis Enrollment Form

All our referral forms are available on our website.

www.pyramidspharmacy.com

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis (ICD-10): <input type="checkbox"/> M80.80 Other Osteoporosis with Current Pathological Fracture Fracture Site: _____ <input type="checkbox"/> M81.0 Age-Related Osteoporosis <input type="checkbox"/> M81.8 Other Osteoporosis without Current Pathological Fracture <input type="checkbox"/> Other: _____	Is patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the start date of treatment? _____ History of osteoporotic fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fracture site: _____ Date of fracture: _____ T-Score: _____ Date: _____	Previously tried/failed therapies and dates: <input type="checkbox"/> Alendronate: _____ <input type="checkbox"/> Ibandronate: _____ <input type="checkbox"/> Risedronate: _____ <input type="checkbox"/> Other: _____ Reason(s) for discontinuing therapy: _____ Contraindications: _____
--	---	--

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 600 mcg/2.4 mL Pen	<input type="checkbox"/> Inject 20 mcg (0.08 mL) subQ once daily.		
	<input type="checkbox"/> 31 G X 5 mm Pen Needles <input type="checkbox"/> 31 G X 8 mm Pen Needles <input type="checkbox"/> Other: _____	<input type="checkbox"/> Use to inject Forteo as directed.		
<input type="checkbox"/> Prolia®	<input type="checkbox"/> 60 mg Prefilled Syringe	<input type="checkbox"/> Inject 60 mg subQ every 6 months.		
<input type="checkbox"/> Tymlos®	<input type="checkbox"/> 3120 mcg/1.56 mL Pen	<input type="checkbox"/> Inject 80 mcg (0.04 mL) subQ once daily.		
	<input type="checkbox"/> 31 G X 5 mm Pen Needles <input type="checkbox"/> 31 G X 8 mm Pen Needles <input type="checkbox"/> Other: _____	<input type="checkbox"/> Use to inject Tymlos as directed.		
<input type="checkbox"/> Zoledronic Acid	<input type="checkbox"/> 5 mg/100 mL Vial	<input type="checkbox"/> Infuse 5 mg IV once every 2 years. <input type="checkbox"/> Infuse 5 mg IV once a year.		

Deliver to: Patient Office Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution Permitted Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.