Osteoporosis Enrollment Form

PYRAMIDS SPECIALTY PHARMACY

All our referral forms are available on our website.

www.pyramidspharmacy.com

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I 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):

❑ M80.80 Other Osteoporosis with Current Pathological Fracture
Fracture Site: _____

❑ M81.0 Age-Related Osteoporosis

❑ M81.8 Other Osteoporosis without Current Pathological Fracture

❑ Other: _____

Is patient new to therapy? ❑ Yes ❑ No
If yes, what is the start date of treatment?
_____

History of osteoporotic fracture? ❑ Yes ❑ No
If yes, fracture site: _____
Date of fracture: _____

T-Score: _____ Date: _____

Previously tried/failed therapies and dates:

❑ Alendronate: _____

❑ Ibandronate: _____

❑ Risedronate: _____

❑ Other: _____

Reason(s) for discontinuing therapy:
_____

Contraindications:
_____

4: Prescription Information

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