

Prescription & Enrollment Form
Osteoporosis



677 Ala Moana Blvd., Suite 404,
 Honolulu, HI 96813-5412

**Four simple steps
 to submit your referral.**

1 PATIENT INFORMATION

New patient Current

Patient's first name _____
 Last name _____ Middle initial _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____ Work phone _____
 Cell phone _____ Evening phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
 Insured's name _____
 Insured's employer _____
 Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____
 Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's first name _____ Last name _____
 Prescriber's title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Office contact e-mail _____
 Office/clinic/institution name _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office Patient's home Clinic
 Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 EXPECTED DATE OF FIRST/NEXT INJECTION _____
 DATE OF LAST INJECTION (if applicable) _____
 Agency nurse to visit home for injection? No Yes
 Agency name and phone _____
 Date labs obtained _____ Calcium _____
 Albumin _____ Vitamin D _____
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Evenity® (romosozumab-aqqg)	Two-pack carton of 105mg/1.17mL prefilled syringes. Total dose 210mg	Inject 210mg (two, 105mg syringes sequentially) subcutaneously once every month for 12 doses in the abdomen, thigh or upper arm. Note: Evenity must be administered by a healthcare provider.	Dispense: <input type="checkbox"/> 1 carton (2 syringes) <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> Forteo® (teriparatide [rDNA origin])	Multi-dose prefilled Forteo delivery device containing 28 daily doses of 20mcg	Inject 20mcg subcutaneously once daily Stop date _____ Cumulative use parathyroid hormone analogs (e.g. teriparatide and abaloparatide) for more than 2 years during a patient's lifetime is not recommended.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills _____
<input type="checkbox"/> Prolia® (denosumab)	60mg/1mL prefilled syringe	Administer 60mg every 6 months as a subcutaneous injection in the upper arm, upper thigh or abdomen. Note: Prolia must be administered by a healthcare provider.	Dispense: <input type="checkbox"/> 1 syringe <input type="checkbox"/> Other _____ Refills _____
<input type="checkbox"/> teriparatide	Multi-dose prefilled teriparatide delivery device containing 28 daily doses of 20mcg	Inject 20mcg subcutaneously once daily Stop date _____ Cumulative use parathyroid hormone analogs (e.g. teriparatide and abaloparatide) for more than 2 years during a patient's lifetime is not recommended.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills _____
<input type="checkbox"/> Tymlos® (abaloparatide)	Multi-dose prefilled Tymlos pen delivering 30 daily doses containing 80mcg of abaloparatide	Inject 80mcg subcutaneously once daily Stop date _____ Cumulative use parathyroid hormone analogs (e.g. teriparatide and abaloparatide) for more than 2 years during a patient's lifetime is not recommended.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills _____
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Dispense as written _____ Date _____ Substitution allowed _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Osteoporosis team at 808.650.6487. To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Forteo is a registered trademark of Eli Lilly and Company.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2020 Accredo Health Group, Inc. | An Express Scripts Company. All rights reserved. OST-00002-H-111720 CRP1706_A0254 amc8550