Prescription & Enrollment Form

Osteoporosis

Four simple steps to submit your referral.

accredo®

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

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
❑ 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: ❑ 1 carton (2 syringes) ❑ Other _____ Refills _____
❑ 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: ❑ 1-month supply ❑ 3-month supply Refills _____
❑ 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: ❑ 1 syringe ❑ Other _____ Refills _____
❑ 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: ❑ 1-month supply ❑ 3-month supply Refills _____
❑ 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: ❑ 1-month supply ❑ 3-month supply Refills _____
❑ 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.