SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025
FAX: 787-704-2027

Osteoporosis Enrollment

Patient Information

Date:_____ Patient SS#:_____ ☐ Male ☐ Female
Patient's First Name:_____ Patient's Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone Number:_____ Alternate Phone Number:_____
DOB:_____ Weight:_____ kgs or lbs (circle one) Recorded Date:_____
Caregiver:_____ Allergies:_____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Clinical Information

DIAGNOSIS:

- ☐ 733.00 Osteoporosis, Unspecified
- ☐ 733.01 Senile Osteoporosis
- ☐ 733.02 Idiopathic Osteoporosis
- ☐ 733.03 Disuse Osteoporosis
- ☐ 733.09 Other Osteoporosis
- ☐ V58.65 Long-term (current) use of Steroids
- ☐ Other: _____

Prior (FAILED) Therapy:

Therapy	Date(s)
☐ **Fosamax**	
☐ **Actonel**	
☐ **Forteo**	
☐ **Prolia**	
☐ **Reclast**	
☐ **Boniva**	
☐ **Other (please list):**_____	

Date of Diagnosis:_____ BMD/T-Score:_____ Is patient new to therapy? ☐ Yes ☐ No
History of osteoporotic fracture? ☐ Yes ☐ No
If no, is patient at high risk? ☐ Yes ☐ No
If yes, date of fracture:_____ Location of fracture:_____

Prescription

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ Forteo®	☐ 600 mcg/2.4 mL Pen	☐ Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use.	☐ 3 pens *(12-week supply)*	_____
☐ BD® Mini Pen Needles	☐ 31G x 3/16"	☐ Use with Forteo® pen once daily as directed	☐ #90 Pen Needles ☐ #30 Pen Needles	_____
☐ Prolia®	☐ 60 mg/1 mL PFS	☐ Inject the contents of 1 syringe (60 mg) subcutaneously every 6 months	1 Prefilled Syringe	_____
☐ Reclast®	☐ 5 mg/100 mL vial	☐ Infuse 5 mg intravenously over no less than 15 minutes once annually	One: 5 mg/100 mL vial	_____
☐ Boniva®	☐ 3 mg/3 mL PFS	☐ Inject the contents of 1 syringe (3 mg) intravenously every 3 months. To be administered by a healthcare professional.	One: 3 mg/3 mL PFS	_____

Forteo® Injection Training

- ☐ Patient has received pen and injection training
- ☐ Physician's office to provide injection training
- ☐ SPS Pharmacy to coordinate injection training

Prescriber Information

Date Shipment Needed:_____ Ship to: _____Patient _____Physician/Clinic
Ship to Other:_____
Physician's Name (please print):_____ Contact Name:_____
Phone #:_____ Fax #:_____ NPI #:_____
Office Address:_____ City:_____ State:_____ Zip:_____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:_____ Date:_____