Wellness Pharmacy AND COMPOUNDING CENTER

OSTEOPOROSIS FORM

Phone: 919-964-5656 | Fax: 919-964-5757
www.wellnessraleigh.com

PATIENT INFORMATION

- ◯ New Patient ◯ Current Patient
- ◯ New Rx ◯ Refill
- ◯ Medicare/Medicaid

Primary Caregiver: _____

PACKAGING

- ◯ Wellness Pharmacy Packaging
- ◯ Vials (Childproof ◯ Yes ◯ No ◯ N/A)

DELIVERY/PICK-UP OPTIONS

- ◯ Patient's Home ◯ Pharmacy Pickup
- ◯ MD's Office
- ◯ MD's office 1st dose at MD's office and remaining refills at patient's home

Date Required: _____

PATIENT INFORMATION

Last Name, First Name _____ Primary Language _____

Primary Phone Number _____ Alternate Phone Number _____

Home Address _____ City, State _____ Zip _____

Shipping Address (if different from home address) _____

Social Security Number _____ Date of Birth _____

Height _____ Weight _____ BMI _____ Gender ◯ M ◯ F Pregnant ◯ Yes ◯ No

PRESCRIBER INFORMATION

Today's Date _____

Physician Name _____ NPI # _____

DEA # _____

Address _____ City, State _____ Zip _____

Phone Number _____ Fax Number _____

Key Office Contact Name _____ Email _____

CLINIC INFORMATION | PLEASE FAX LABS, CURRENT PRESCRIPTION MEDICATIONS/OTC PROFILE, AND HISTORY

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: _____

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: _____

Prior (FAILED) Therapy:

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

PRESCRIPTION INFORMATION OR ATTACH RX

MEDICATION	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Forteo ®**	☐ 600 mcg/2.4 mL Pen	☐ Inject 1 dose (20 mcg) subcutaneously once daily. Discard device 28 days after first use.	☐ 1 pen (4-week supply) ☐ 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	☐ Every 6 months, inject the contents of 1 syringe (60 mg) subcutaneously.	☐ 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	0
☐ **Boniva ®**	☐ 3 mg/3 mL PFS	☐ Every 3 months, inject the contents of 1 syringe (3 mg) intravenously. To be administered by a healthcare professional.	☐ One: 3 mg/3 mL PFS	
☐ **Tymlos**	☐ 200mcg/mL	☐ Inject 80mcg subcutaneous once daily.	☐ 1 device (4-week supply) ☐ 3 device (12-week supply)	

INJECTION TRAINING FOR FORTEO

- ☐ Wellness Pharmacy to Coordinate
- ☐ Office to Coordinate
- ☐ Patient has received injection training

RN/LPN to teach administration of injectable to caregiver/patient (in accordance with state laws)

I hereby authorize **Wellness Pharmacy and Compounding Center** and its representatives to act as a prior authorization designated agent. I authorize them to deal with medical and prescription insurance companies and to organize/receive patient lab values.

◯ Patient is interested in Patient Support Programs as necessary/applicable

Ancillary kits and supplies provided as necessary/applicable

Doctor/Prescriber Name - Dispense as Written _____ Date _____

Doctor/Prescriber Name - Substitution Permissible _____ Date _____

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