DOTTIE'S PHARMACY
specialty & compounding

Osteoporosis Medications

Enrollment Form

325 Folly Road Suite 101
Charleston, SC 29412
PH: (843) 501-9500
FAX: (843) 414-7453

Date: _____ Needs by date: _____

Ship to: Patient ___ Office: ___ Other: _____

Patient Information:

Patient Name: _____
Address: _____
City, State, Zip: _____
Main Phone: _____
Alternate Phone: _____
Last 4 of SSN: _____ Height _____○ in ○cm Weight _____○ lbs ○ kg
Date of Birth: _____ ○ Male ○ Female

Prescriber Information:

Prescriber Name: _____
DEA: _____ NPI: _____
Group: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact Person: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF PRESCRIPTION CARD AND MEDICAL CARD (FRONT AND BACK)

Clinical Information: Please attach clinical notes/labs for the prior authorization process

Primary Diagnosis: _____ Date of Diagnosis/ Years with Disease: _____ Allergies :_____ ○ NKDA

ICD -10 code: ○ M81.0 Age-related Osteoporosis without current pathological fracture ○ M81.6 Localized Osteoporosis

○ M81.8 Other Osteoporosis without current pathological fracture ○ Other ICD-10 Code: _____

Therapy: ○ New ○ Reauthorization ○ Restart Previous Therapies _____

Prior Failed medications: _____ Reason for discontinuation: _____

Current Medications: _____ Renal Dysfunction: ○ Yes ○ No Current SCr: _____ or CrCl: _____ mL/min

Contraindications/ reasons to avoid drugs below: ○ Hypocalcemia ○ History of VTE ○ History of breast cancer ○ Oral Meds: inability to sit up/ stand for at least 30 min.

○ Oral Meds: abnormalities in esophagus or ability to swallow ○ Oral Meds: at an increased risk of aspiration or dysphagia ○ Tymlos: Hypercalcemia

Osteoporosis Dosing as: ○ Treatment (Tx) ○ Prevention (PREV) Recent Lab results: Calcium: _____ Albumin: _____ Vitamin D [25(OH)D]: _____

BMD/T-Score: _____ Date: _____ FRAX Score: _____ Date: _____ Is the patient at a high risk for fracture? ○ Yes ○ No

Does the patient have a history of fracture? ○ Yes ○ No If YES list location of fracture(s) _____ Date of fracture(s) _____

Prescription Information

Medications	Dose/ Strength	Directions	Quantity	Refills
Actonel® (risedronate)	○ 5 mg oral tab ○ 35 mg oral tab ○ 150 mg oral tab	○ 5 mg PO once daily ○ 35 mg PO once **weekly** ○ 150 mg PO **ONCE MONTHLY**		
Atelvia® (risedronate delayed-release)	○ 35 mg DR oral tab	○ Tx only: 35 mg DR tab PO once weekly		
Boniva® (ibandronate)	○ 150 mg oral tab ○ 3 mg/ 3 mL Prefilled Syringes	○ 150 mg PO **ONCE MONTHLY** ○ Tx only: Infuse 3 mg IV every 3 months		
Duavee® (Estrogens/ Bazedoxifene)	○ 0.45 mg/ 20 mg oral tab	○ PREV only: one tablet PO daily		
Evista® (raloxifene)	○ 60 mg oral tab	○ 60 mg PO once daily		
Forteo® (teriparatide)	○ 600 mcg/ 2.4 mL Prefilled Delivery Device	○ Tx only: Inject 20 mg SC **ONCE DAILY**		
Fosamax® (alendronate)	○ 5 mg oral tab ○ 10 mg oral tab ○ 35 mg oral tab ○ 70 mg oral tab	○ PREV only: 5 mg PO once daily ○ Tx only: 10 mg PO once daily ○ PREV only: 35 mg PO once **weekly** ○ Tx only: 70 mg PO once **weekly**		
Prolia® (denosumab)	○ 60 mg/mL Prefilled Syringe	○ Tx only: Inject 60 mg SC once every 6 months		
Reclast® (zoledronic Acid)	○ 5 mg/ 100 mL vial	○ Tx only: Infuse 5 mg IV once a year ○ PREV only: Infuse 5 mg IV once every 2 years		
Tymlos™ (abaloparatide)	○ 3120 mcg/ 1.56 mL Pen	○ Tx only: Inject 80 mcg SC **ONCE DAILY**		
Other: _____				

Prescriber Signature: _____ _____ Date: _____

Dispense as Written Product Substitution Permitted