ATLANTIC SPECIALTY DRUGS

Phone: 562-912-7940
Fax: 562-912-7944
4233 Atlantic ave, Long Beach, CA 90807

Osteoporosis Enrollment Form

(Please use black ink)

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Fill out entirely or fax a copy of patient's insurance card including both sides)*

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____

Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

MEDICAL INFORMATION *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ ICD-10 _____ Description _____

Disease State Description:

☐ Postmenopausal osteoporosis with high fracture risk (female)

☐ Postmenopausal osteoporosis prophylaxis

☐ Hypogonadal osteoporosis with high fracture risk (male)

☐ Glucocorticoid-induced osteoporosis treatment/prophylaxis

☐ Paget's disease

☐ Other: _____

Date of Diagnosis _____

Test Results: **WNL:**

☐ Serum calcium _____ ☐ Yes ☐ No

☐ SCr/CrCl _____ ☐ Yes ☐ No

☐ BMD _____ ☐ Yes ☐ No

☐ T score _____ ☐ Yes ☐ No

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2

Allergies _____

Fracture History _____

Prior Failed Therapies:

☐ Actonel® (risedronate) ☐ Boniva® (ibandronate)

☐ Fosamax® (alendronate) ☐ Prolia® (denosumab)

☐ Reclast® (Zoledronic Acid Injection)

Concomitant Medications _____

Additional Comments _____

Treatment Start Date _____ Treatment End Date _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Boniva injection				
☐ Forteo®				
☐ Prolia				
☐ Reclast				

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

Prescriber's Signature _____ _____

PRODUCT SUBSTITUTION PERMITTED *DISPENSE AS WRITTEN*