PHARMACA
SPECIALTY PHARMACY

OSTEOPOROSIS ENROLLMENT FORM

Fax: **888.882.3341**
Call: **855.465.8892**

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt Phone: _____
Email: _____
DOB: _____ ☐ M ☐ F Last 4 of SSN: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: _____ Drug Allergies: ☐ NKDA ☐ _____

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: _____

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: _____

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: _____

PRESCRIPTION INFORMATION:

Medication	Dose and Form	Directions	Qty	Refills
☐ **Forteo**	☐ 600 mcg/2.4 mL Pen	☐ Inject 20 mcg SC once daily	1	
☒ **Pen Needles**	☐ 31 Gauge ☐ 5 mm		100	
☐ **Prolia**	☐ 60 mg/mL Prefilled Syringe	☐ Inject 60 mg SC every 6 months	1	
☐ **Tymlos**	☐ 3120 mcg/1.56 mL Pen	☐ Inject 80 mcg SC once daily into the periumbilical region of the abdomen	1	
☒ **Pen Needles**	☐ 31 Gauge ☐ 8 mm		100	
☐				

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

x PHYSICIAN SIGNATURE REQUIRED _____ Substitution Permitted Date

x _____ Dispense as Written Date