Phone: 417-719-4510
Fax: 417-893-3908
specialty.alpspharmacy.com

Osteoporosis

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, ZIP: _____
Home Phone: _____ Alternate Phone: _____
Caregiver: _____ Email: _____
DOB: _____ Social Security#: _____
Gender: ☐ Male ☐ Female Comorbidities: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Address: _____
City, State, ZIP: _____
Phone: _____ Fax: _____
NPI: _____ Tax ID: _____
DEA: _____
Office Contact: _____ Phone: _____
Contact Email: _____

INSURANCE INFORMATION

Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.

CLINICAL INFORMATION [Please fax all pertinent clinical and lab information and/or attach separate sheet if needed.]

Diagnosis: ☐ M81.0, Age-related osteoporosis without current pathological fracture ☐ M80.0 ___, Age-related osteoporosis with current pathological fracture
☐ Other: _____ ☐ Secondary ICD Code if Applicable: _____

Prior Therapy ☐ Yes ☐ No	Approx. Therapy Start/End Dates	Reason for Discontinuation of Therapy
☐ Actonal®	_____ to _____	
☐ Boniva®	_____ to _____	
☐ Forteo®	_____ to _____	
☐ Fosamax®	_____ to _____	
☐ Prolia®	_____ to _____	
☐ Reclast®	_____ to _____	
☐ Other: _____	_____ to _____	
☐ Other: _____	_____ to _____	

Concomitant Medications: _____
Additional Information: _____

Date of Diagnosis: _____
Is the patient new to therapy?: ☐ Yes ☐ No
History of Osteoporotic Fracture?: ☐ Yes ☐ No
If yes, Location of Fracture: _____ Date of Fracture: _____
Is patient high risk for fracture?: ☐ Yes ☐ No
Contraindication(s) to bisphosphonate therapy?: ☐ Yes ☐ No
If yes, ☐ Dysphagia ☐ GERD ☐ Ulcer ☐ Other: _____
BMD/T-Score: _____ Date: _____
FRAX Score: _____ Date: _____
Serum Calcium: _____ Date: _____
SCr/CrCl: _____ Date: _____

PRESCRIPTION INFORMATION

Medication	Directions	Strength	Quantity	Refills
☐ Boniva	☐ Inject 1 syringe (3mg) IV every 3 months. To be administered by a healthcare professional.	☐ 3mg/3mL	☐ 1 PFS	
☐ Forteo®	☐ Inject 1 dose (20mcg) Sub-Q once daily Discard device 28 days after first use.	☐ 20mcg/2.4mL	☐ 1 Pen (4-week supply) ☐ 3 Pens (12-week supply)	
☐ Pen Needles	☐ Use with Forteo® delivery device as directed	☐ 5mm ☐ 6mm ☐ 8mm	☐ 1 box (100 needles)	
☐ Prolia®	☐ Inject 1 syringe (60 mg) sub-Q every 6 months	☐ 60mg/mL	☐ 1 PFS	
☐ Tymlos®	☐ Inject 80mg Sub-Q once daily	☐ 2mg/mL	☐ 1 PFS (30 day supply)	
☐ Pen Needles	☐ Use with Tymlos® delivery device as directed	☐ 8mm	☐ 1 box (100 needles)	

☐ Other Medication: _____ Dose: _____ Quantity: _____ Refills: _____
Direction(s): _____

INJECTION TRAINING

☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRESCRIPTION DELIVERY

☐ Patient's Home ☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: _____ Needs by Date: _____

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____
PRODUCT SUBSTITUTION PERMITTED ***Dispense As Written***

CONFIDENTIALITY NOTICE

Disclaimer: Alps can accept only original prescription drug orders from patients, and faxed prescriptions can be accepted only from the prescribing practitioners.