Sunray Specialty Pharmacy

Osteoporosis Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____
Alternate Phone: _____
DOB: _____
Last 4 Digits of SS#: _____
Gender: _____
Language Preference: _____

PRESCRIBER INFORMATION:

Prescriber's Name: _____
DEA: _____
NPI: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact Person's Phone: _____

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

☐ M80.00 Osteoporosis with current pathological fracture
☐ M81.00 Osteoporosis age-related with current pathological fracture
☐ M81.8 Other osteoporosis without current pathological fracture
Other Diagnosis:
ICD-10 Code: _____
Description: _____
Disease State Description:
☐ Postmenopausal osteoporosis with high fracture risk
☐ Postmenopausal osteoporosis prophylaxis
☐ Hypogonadal osteoporosis with high fracture risk
☐ Glucocorticoid-induced osteoporosis treatment/prophylaxis
☐ Paget's disease
☐ Other: _____
Date of Diagnosis: _____

Additional information:

Therapy: New Reauthorization Restart
Weight: _____ kg/lb Height _____ cm/in BSA _____ m^2
Allergies: _____
Fracture History: _____
Prior Failed Therapies: ☐ Risedronate ☐ Ibandronate ☐ Alendronate
☐ Prolia® (denosumab) ☐ Reclast® (zoledronic acid)
Concomitant Medications: _____
_____
Injection Training Required: ☐ Yes ☐ No

Start Date _____ End Date _____

Test Results:
☐ Serum calcium _____
☐ SCr/CrCl _____
☐ BMD _____
☐ T score _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Forteo®	☐ 600mcg/2.4mL PFS			
Prolia®	☐ 60mg PFS			
Reclast®				
Tymlos®	☐ 80mcg Pen			
OTHER: _____				

Please deliver to: ☐ Patient ☐ Office ☐ Other _____ by this date: _____

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.

☐ Product Substitution Permitted ☐ Dispense as Written

Prescriber's Signature: _____