elixir
SPECIALTY PHARMACY

Osteoporosis Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ **New to Therapy**
☐ **Current Therapy**

Customer Information

Customer Name: ______________________________
Date of Birth: _________ Sex: M or F Caregiver: ______________
Address: ______________________________
City: ______________ State: __________ Zip: __________
Home Phone: ______________ Work Phone: ______________
Cell Phone: ______________ E-mail: ______________
Please attach copy of front and back of customer's prescription insurance card(s) if applicable
Insurance Company Name: ______________________________
Insurance Company Phone: ______________________________
Policy holder: ______________________________
Policy holder Employer: ______________________________
Relationship to Customer: ______________________________
ID# ______________ Group# ______________

Prescriber Information

Practice/ Organization Name: ______________________________
Prescriber Name: ______________________________
Address: ______________________________
City: ______________ State: __________ Zip: __________
Phone#: ______________ Fax#: ______________
DEA# ______________ NPI# ______________
License#: ______________ Medicaid UPIN#: ______________
Physician Specialty: ______________________________

Date Shipment Needed: ______________________________
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:** ______________
Shipment Address: ______________ Attn: __________
City: ______________ State: __________ Zip: __________

If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

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20-4751

Clinical Information and Prescription

Diagnosis: ☐ M81.0 Age-related osteoporosis w/o fracture ☐ M80.0 Age-related osteoporosis w/ fracture ☐ M81.8 Other osteoporosis w/o fracture ☐ M80.80 Other osteoporosis w/fracture
☐ Other: _ _ . _ _ _ Description: ______________________________
History of fracture: ☐ Yes ☐ No Bone Density T-score: ______________
Risk Factors Present: ______________________________
Patients Allergies: ______________________________
____
Latex allergy: ☐ Yes ☐ No
Patient Weight: _________ lbs or kgs Patient Height: _______ cm or in Date: ____/____/______

Medication History

Previous Medications	Duration of Use	Reason for Discontinuation

☐ **Boniva®** (ibandronate) 3mg IV bolus every 3 months
☐ **Evenity®** (romosozumab) 210 mg (2 injections) SC once every month
☐ **Forteo®** (teriparatide) Pen 20mcg SC once daily. Dispense with #100 pen needles
Injection training needed? ☐ Yes ☐ No ☐ In-office training scheduled
Anticipated date of first injection: ____/____/_______
☐ **Prolia®** (denosumab) 60mg SC every 6 months
☐ **Reclast®** (zoledronic Acid) 5mg IV once yearly
☐ **Tymlos®** (abaloparatide) Pen 80mcg SC once daily. Dispense with #100 pen needles
Injection training needed? ☐ Yes ☐ No ☐ In-office training scheduled
Anticipated date of first injection: ____/____/_______

Quantity Prescribed: ☐QS 30 days or interval listed above ☐Other: __________
Refills Authorized: ☐ 0 ☐1 ☐2 ☐3 ☐ 6 mos ☐1 yr ☐Other: __________

Date Shipment Needed: ____/____/_______ **Ship to:** ☐ **Patient** ☐ **Prescriber** ☐ **Infusion Clinic**
Shipment Address: ______________________________ Attn: ______________
City: ______________________ State: ______________ Zip: __________

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X______________________________ ____/____/__________
Physician Signature (no stamps) **Date**

If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided: