Osteoporosis Enrollment Form Medications A-S

(Evenity, Forteo, Prolia, Reclast)



Fax Referral To: 1-877-232-5455

Phone: 1-800-896-1464 Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

		Six Simple Steps to Su	ubmitting a Referral		
PATIENT I	NFORMATION (Co.	mplete or include demographic	sheet)		
Address:					
Gender: Ma	ale Female				
Preferred Cont	tact Methods: \square Phone	(to primary # provided below)	Text (to cell # provided below) 🗌 Er	mail (to email provided below)	
			lty Pharmacy will attempt to contact		
Primary Phone	:		Alternate Phone:		
If Minor, Paren	nt/Caregiver/Guardian	Name (Last, First):			
Relationship to	o minor:				
Email:		Last Fo	our of SSN: Primary L	_anguage:	
PRESCRIP	BER INFORMATIO	N.			
Prescriber's Na			ate License #:		
NDI #	DEA #•	Group or Ho	spital:		
Phone:		Conto	r, State, ZIP Code: Contact's Phone:		
_					
3 INSURAN	CE INFORMATION	Please fax copy of prescription	on and insurance cards with this	form, if available (front and back)	
DIAGNOS	IS AND CLINICAL	INFORMATION			
			Other:		
		ip to Patient Office C)u iei		
Diagnosis (ICE					
_		rith current pathological fractur			
		vithout current pathological frac	cture		
	e: Descrip	tion			
	al Information:				
Allergies:		Weight	:lb/kg Height:	in/cm	
PRESCRIP	TION INFORMAT	ION			
MEDICATION			DIRECTIONS	QUANTITY/REFILLS	
Evenity	105 mg/1.17 mL	Administer two consecutives			
		each) for a total dose of 210 r	ng once monthly for 12 doses	Refills: 11	
				Quantity:	
	600 mcg/2.4 mL			1 device (28-day supply)	
Forteo	(250mcg/mL)	Inject 20 mcg (0.08 mL) subcutaneously once daily.		3 devices (84-day	
	Delivery Device			supply)	
	Delivery Device			Refills:	
	31G Pen Needles:			Quantity:	
				<u> </u>	
Forteo	∐ 5 mm	Use with Forteo delivery devi	ice as directed.	28-day supply	
	6 mm	1		84-day supply	
	8 mm			Refills:	
Prolia	60 mg	Inject 60 mg subcutaneously every 6 months.		Quantity:	
	60 mg			Refills:	
		Infuse 5 mg IV once a year over no less than 15 minutes.			
Reclast	5 mg	1 <u> </u>	/ 2 years over no less than 15	Quantity: 1 vial	
	J9	minutes.		Refills:	
☐ Patient is intereste	ed in patient support programs	STAMP SIGNATURE NO	OT ALLOWED Ancillary suppl	lies and kits provided as needed for administration	
_			(STAMP SIGNATURE N	·	
			1		
"Dispense As Written" / Brand Medically Necessary DAW / May Not Substitute		/ / Do Not Substitute / No Substitution /	May Substitute / Product Selection Pern Substitution Permissible	May Substitute / Product Selection Permitted /	
Prescriber's Signature:		Date:		Date:	
riestiner s 31(yııatur e	Date:	Prescriber's Signature:	Date:	
CA, MA, NC & PR: In	nterchange is mandated unless Pre	escriber writes the words "No Substitution"	ATTN: New York and lowa	a providers, please submit electronic prescription	
			edge, with supporting documentation	. Control of the cont	

signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Osteoporosis Enrollment Form Medications T-Z

(Teriparatide, Tymlos)

Patient Name: Prescriber Name: _		Patient DOB: Prescriber Phone:			
_	N INFORMATION				
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILLS	
Teriparatide njection* *FDA approved reatment ulternative to Forteo-Not sutomatically rubstituted for Forteo)	620 mcg/2.48 mL (250 mcg/mL) Delivery Device	Inject 20 mcg (0.08 mL) subcutaneously once daily.		Quantity: 1 device (28-day supply) 3 devices (84-day supply) supply) Refills:	
Teriparatide	31G Pen Needles: 5 mm 6 mm 8 mm	Use with Teriparatide Delivery Device as directed.		Quantity: 4-week supply 12-week supply Refills:	
] Tymlos	3120 mcg/1.56 mL	Inject 80 mcg (0.04 mL) subcutaneously once daily.		Quantity: 1 device (30-day supply 3 devices (90-day supply) Refills:	
Tymlos	31G Pen Needles: 5 mm 6 mm 8 mm	Use with Tymlos delivery device as directed. STAMP SIGNATURE NOT ALLOWED Ancillary Supplie		Quantity: 30-day supply 90-day supply Refills: as and kits provided as needed for administra	
Patient is interested in pa			STAMP SIGNATURE NO		
"Dispense As Written" / Brand Medically Necessary / Do Not S DAW / May Not Substitute Prescriber's Signature:			May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:Date:		
A, MA, NC & PR: Intercha	nge is mandated unless Prescriber w	rites the words "No Substitution"	ATTN: New York and lowa	providers, please submit electronic prescrip	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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