Osteoporosis Enrollment Form Medications A-S

(Evenity, Forteo, Prolia, Reclast)



Fax Referral To: 1-888-280-1191 OR 787-759-4161 Phone: 1-888-280-1190 OR 787-759-4162

Email Referral To: Customer.ServiceFax@CVSHealth.com Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Address:	PATIENT I Address:		Six Simple Steps to Simplete or include demographic	sheet)		
Preferred Contact Methods: Phone (to primary # provided below) Text to cell # provided below Mote: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: Alternate Phone: Primary Language: Primar		Ja D Famala		City, State, ZIP Code:		
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: Alternate Phone: Alternate Phone: If Minor, Parent/ Caregiver/Guardian Name (Last, First): Relationship to minor: Email: Last Four of SSN: Primary Language: Prescriber's Name: Note: Prescriber's Name: DEA #: Group or Hospital: Address: City, State, ZiP Code: Phone: Contact Person: Contact Person: Contact Person: Insurance cards with this form, if available (front and and insurance cards with this form, if available (front and	_		, , , , , , , , , , , , , , , , , , ,		77.	
Alternate Phone:						
Minor, Parent/Caregiver/Guardian Name (Last, First): Relationship to minor:						
PRESCRIBER INFORMATION Prescriber's Name:	filmary Phone	t (O = u = = i: . = u (O : . = u di = u	Name (Last First)	Alternate Phone		
PRESCRIBER INFORMATION Prescriber's Name: State License #:						
PRESCRIBER INFORMATION Prescriber's Name:	Relationship to	o minor:				
State License #: State License #: NPI #: DEA #: Group or Hospital: Address: City, State, ZIP Code: Contact's Phone: Fax Contact Person: Contact's Phone: State License #: City, State, ZIP Code: Contact's Phone: Fax Contact Person: Contact's Phone: State License #: City, State, ZIP Code: Contact's Phone: State License #: Contact Person: Contact's Phone: State License #: Contact Person: Contact's Phone: State License #: Contact's Phone: Contact's P	_			our of SSN: Primary La	anguage:	
Prescriber's Name: DEA #: Group or Hospital: DEA #: Group or Hospital: City, State, ZIP Code: Contact's Phone: Fax Contact Person: Contact's Phone: Fax Contact Person: Contact's Phone: Group or Hospital: Contact Person: Contact's Phone: DEA #: Contact Person: Contact's Phone: Contact's Phone: DEA #: Contact Person: Contact's Phone: DEA #: Contact Person: Contact's Phone: DEA #: DEA	PRESCRIE	BER INFORMATIOI	N			
Address:				ate License #:		
Address:	NPI#:	#· DFA #· Group or H		spital:		
INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and plagnosis AND CLINICAL INFORMATION	Address:	Gloup (City, State, ZIP Code:		
INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and DIAGNOSIS AND CLINICAL INFORMATION) Needs by Date: Ship to: Patient Office Other:	Phone:	Fa	Conta	Contact Person: Contact's Phone:		
DIAGNOSIS AND CLINICAL INFORMATION Needs by Date:	_					
PRESCRIPTION INFORMATION DOSE & DIRECTIONS QUANTITY/REFILE	Needs by Date Diagnosis (ICC M80.0 Age M81.0 Age I	: Sh D-10): related osteoporosis w Related osteoporosis w	ip to: Patient Office Co rith current pathological fractur rithout current pathological frac	re cture		
PRESCRIPTION INFORMATION			tion			
PRESCRIPTION INFORMATION MEDICATION STRENGTH DOSE DIRECTIONS QUANTITY/REFIL Los mg/1.17 mL	<u>Patient Clinica</u>	<u>al Information:</u>				
DOSE & DIRECTIONS QUANTITY/REFILE	ıllergies:		Weight	::lb/kg Height:ii	n/cm	
Evenity 105 mg/1.17 mL Administer two consecutive subcutaneous injections (105 mg each) for a total dose of 210 mg once monthly for 12 doses Quantity: 2 syringes Refills: 11 Quantity: Quantity: 1 device (28-day surply) 3 devices (84-day supply) Refills: 31G Pen Needles: Quantity: 28-day supply Refills: 28-day supply Refills: Quantity: 28-day supply Refills: 28-day supply Refills: Quantity: 28-day supply Refills: 28-day supply	DDESCOID	TION INCODMAT	ION			
Evenity 105 mg/1.17 mL Administer two consecutive subcutaneous injections (105 mg each) for a total dose of 210 mg once monthly for 12 doses Refills: 11				PIDECTIONS	OHANITITY (BEELL C	
Evenity 105 mg/1.17 mL each) for a total dose of 210 mg once monthly for 12 doses Refills: 11	MEDICATION	STRENGTH	DOSE	X DIRECTIONS	QUANTITY/REFILLS	
Forteo Good mcg/2.4 mL (250mcg/mL) Delivery Device Inject 20 mcg (0.08 mL) subcutaneously once daily. Good managed of a dark of the product Selection Permitted / Substitute / Product Selection Permitted / Substitution / Permissible May Substitute / Product Selection Permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Permissible Good managed of the product selection permitted / Substitution Per	_ Evenity	105 mg/1.17 mL		, ,		
Forteo	Forteo	(250mcg/mL)	Inject 20 mcg (0.08 mL) subo	nject 20 mcg (0.08 mL) subcutaneously once daily.		
Prolla 60 mg Inject 60 mg subcutaneously every 6 months. Refills: Refills:	Forteo	☐ 5 mm ☐ 6 mm	Use with Forteo delivery devi	se with Forteo delivery device as directed.		
Reclast 5 mg Infuse 5 mg IV once every 2 years over no less than 15 Refills:	Prolia	60 mg	Inject 60 mg subcutaneously	ject 60 mg subcutaneously every 6 months.		
PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) *Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / Substitute / Product Selection Permitted / Substitution Permissible	Reclast	5 mg	Infuse 5 mg IV once every	Infuse 5 mg IV once every 2 years over no less than 15		
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute May Substitute / Product Selection Permitted / Substitution Permissible	Patient is intereste	d in patient support programs	STAMP SIGNATURE NO	OT ALLOWED Ancillary supplie	es and kits provided as needed for administrati	
DAW / May Not Substitute Substitution Permissible	6	PRESCRIBER SI	GNATURE REQUIRED	(STAMP SIGNATURE NO	OT ALLOWED)	
· · · · · · · · · · · · · · · · · · ·	DAW / May Not Substitute			Substitution Permissible	_	
l de la companya de		y : <u></u>				

The information provided above is true and accurate to the best ofmy 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.

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.		Quantity: 30-day supply 90-day supply Refills: as and kits provided as needed for administra
Patient is interested in pa			STAMP SIGNATURE NO	
AW / May Not Substitute	and Medically Necessary / Do No	t Substitute / No Substitution /	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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

©2022 CVS Specialty Inc. or one of its affiliates. 75-42197A 01/25/22