Community Memorial Pharmacy
P: 844-236-8311
F: 805-948-5176

Community Memorial HEALTHCARE

☐ **New/Changed Dose** **Osteoporosis Evenity™, Forteo®, Prolia®, Teriparatide**

Prescriber Information

Prescriber Name _____ ☐ MD ☐ DO ☐ NP ☐ PA NPI _____

Office Contact _____ Practice Name / Collaborating MD _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patient's Name _____ Last 4 Digits of SS# _____ DOB / /

Sex ☐ M ☐ F Weight _____ Height _____ Diabetic? ☐ Y ☐ N

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work/Cell _____ HIPAA Contact _____

Emergency # _____

Interpreter Needed? ☐ Y ☐ N | Allergies ☐ Y ☐ N If Yes, list allergies _____

Insurance Information

Primary Insurance _____ Policy ID _____ Group# _____

BIN _____ PCN _____

Policyholder Name _____ Policyholder DOB / /

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES, AND LAB VALUES

ICD-10/Diagnosis Code

☐ Osteoporosis with current pathological fracture (M80. _____)

☐ Osteoporosis without current pathological fracture (M81. _____)

☐ Age-related osteoporosis (M80.0 _____)

☐ Paget's Disease (M88) ☐ Other _____

T-Score _____ Previous Therapies _____

History of Fractures ☐ Y ☐ N Fracture Code _____ Site Fracture Code _____

Date of Diagnosis / / First Dose ☐ Y ☐ N

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Prescription Information

Medication	Quantity/Dose	Sig	Refills
☐ **EVENITY**™	☐ 1 carton (2x105 mg/1.17 ml PFS)	☐ Inject two syringes (210 mg) SQ once monthly	
☐ **FORTEO**® *Needles required	☐ 1 carton (1x600 mcg/2.4ml Pen) ☐ 3 cartons (3x600 mcg/2.4ml Pen) ☐ Pen needles – _____ box(es) of 30	☐ Inject 20 mcg SQ every day ☐ Use one needle daily with injection	
☐ **PROLIA**®	☐ 60 mg/ml PFS	☐ Inject 60 mg SQ every six months	
☐ **TERIPARATIDE** *Needles required	☐ 1 carton (1x620 mcg/2.48 ml Pen) ☐ 3 cartons (3x620 mcg/2.48 ml Pen) ☐ Pen needles – _____ box(es) of 30	☐ Inject 20 mcg SQ every day ☐ Use one needle daily with injection	
☐ Other			

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training
☐ Community Memorial Healthcare to coordinate injection training

By signing this form and utilizing our services, you are authorizing Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature _____ *Substitution Permitted*
Date _____

Prescriber Signature _____ *Dispense as Written*
Date _____

If brand is required, please write "DAW" in the box to the right. ☐