

# Osteoporosis Enrollment Form Medications A-S

(Evenity, Forteo, Prolia, Reclast)



Fax Referral To: 1-877-232-5455  
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727  
NCPDP: 1203417

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_

Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Parent/Caregiver/Legal Guardian Name (Last, First): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

### 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_ Ship to:  Patient  Office  Other: \_\_\_\_\_

#### Diagnosis (ICD-10):

M80.0 Age related osteoporosis with current pathological fracture

M81.0 Age Related osteoporosis without current pathological fracture

Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> 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
<input type="checkbox"/> Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: <input type="checkbox"/> 1 device (28-day supply) <input type="checkbox"/> 3 devices (84-day supply) Refills: _____
<input type="checkbox"/> Forteo	31G Pen Needles: <input type="checkbox"/> 5 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 8 mm	Use with Forteo delivery device as directed.	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply Refills: _____
<input type="checkbox"/> Prolia	60 mg	Inject 60 mg subcutaneously every 6 months.	Quantity: _____ Refills: _____
<input type="checkbox"/> Reclast	5 mg	<input type="checkbox"/> Infuse 5 mg IV once a year over no less than 15 minutes. <input type="checkbox"/> Infuse 5 mg IV once every 2 years over no less than 15 minutes.	Quantity: 1 vial Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" \_\_\_\_\_ ATTN: New York and Iowa providers, please submit electronic prescription

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.

# Osteoporosis Enrollment Form

## Medications T-Z

(Teriparatide, Tymlos)

### Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Teriparatide Injection* <i>(*FDA approved treatment alternative to Forteo-Not automatically substituted for Forteo)</i>	620 mcg/2.48 mL (250 mcg/mL) Delivery Device	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: <input type="checkbox"/> 1 device (28-day supply) <input type="checkbox"/> 3 devices (84-day supply) Refills: _____
<input type="checkbox"/> Teriparatide	31G Pen Needles: <input type="checkbox"/> 5 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 8 mm	Use with Teriparatide Delivery Device as directed.	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Tymlos	3120 mcg/1.56 mL	Inject 80 mcg (0.04 mL) subcutaneously once daily.	Quantity: <input type="checkbox"/> 1 device (30-day supply) <input type="checkbox"/> 3 devices (90-day supply) Refills: _____
<input type="checkbox"/> Tymlos	31G Pen Needles: <input type="checkbox"/> 5 mm	Use with Tymlos delivery device as directed.	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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.

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