# 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 |
|---|---|---|---|
| ☐ 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<br>Refills: 11 |
| ☐ Forteo | 600 mcg/2.4 mL (250mcg/mL) Delivery Device | Inject 20 mcg (0.08 mL) subcutaneously once daily. | Quantity:<br>☐ 1 device (28-day supply)<br>☐ 3 devices (84-day supply)<br>Refills: ____________ |
| ☐ Forteo | 31G Pen Needles:<br>☐ 5 mm<br>☐ 6 mm<br>☐ 8 mm | Use with Forteo delivery device as directed. | Quantity:<br>☐ 28-day supply<br>☐ 84-day supply<br>Refills: ____________ |
| ☐ Prolia | 60 mg | Inject 60 mg subcutaneously every 6 months. | Quantity: ____________<br>Refills: ____________ |
| ☐ Reclast | 5 mg | ☐ Infuse 5 mg IV once a year over no less than 15 minutes.<br>☐ Infuse 5 mg IV once every 2 years over no less than 15 minutes. | Quantity: 1 vial<br>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 | May Substitute / Product Selection Permitted / Substitution Permissible |
|---|---|
| **Prescriber's Signature:** ______________ **Date:** ________ | **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: ____________________
Patient Address: ______________________________________________________________________________________
Prescriber Name: ______________________________________ Prescriber Phone: ___________________________________________

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Teriparatide Injection* *(*FDA approved treatment alternative to Forteo-Not automatically substituted 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) 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 | Use with Tymlos delivery device as directed. | Quantity: ☐ 30-day supply ☐ 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 **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.

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