Osteoporosis Enrollment Form
Medications A-S
(Evenity, Forteo, Prolia, Reclast)

CVS specialty®

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

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 Refills: 11
☐ Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: ☐ 1 device (28-day supply) ☐ 3 devices (84-day supply) Refills: _____
☐ Forteo	31G Pen Needles: ☐ 5 mm ☐ 6 mm ☐ 8 mm	Use with Forteo delivery device as directed.	Quantity: ☐ 28-day supply ☐ 84-day supply Refills: _____
☐ Prolia	60 mg	Inject 60 mg subcutaneously every 6 months.	Quantity: _____ Refills: _____
☐ Reclast	5 mg	☐ Infuse 5 mg IV once a year over no less than 15 minutes. ☐ 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: _____
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

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"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

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