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

(Evenity, Forteo, Prolia, Reclast)

Six Simple Steps to Submitting a Referral         IPATIENT INFORMATION (Complete or include demographic sheet)       DOB:Gender::DOB:Gender::Nale		CVS specialty	<ul> <li>Fax Referral To: 1-855-297-1270</li> <li>Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 009</li> </ul>	hone: 1-888-280-1190 82 NCPDP: 4026325
PATIENT INFORMATION (Complete or include demographic sheet)				
Patient Name:	<b>PATIENT INF</b>	<b>ORMATION</b> (Comp		
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, email and/or text messages from CVS Specialty* about your prescription(s), account, and health care. Standard data rates apply. Message frequency var         # funable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.       Primary Phone:         Primary Phone:	Patient Name:		DOB:	Gender: 🗌 Male 🗍 Female
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, email and/or text messages from CVS Specialty* about your prescription(s), account, and health care. Standard data rates apply. Message frequency var if unable to contact via text or email. Specialty Pharmacy will attempt to contact by phone.         Primary Phone:	Address:		City, State, ZIP Code:	
and/or text messages from CVS Specialty* about your prescription(s), account, and health care. Standard data rates apply. Message frequency var if unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. Primary Phone: 	Preferred Contac	ct Methods: 🗌 Phone	(to primary # provided below) Text (to cell # provided below)	Email (to email provided below)
If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.				
Primary Phone:				apply. Message frequency varies.
Email:				
Parent/Caregiver/Legal Guardian Name (Last, First):       Relationship to patient:         PRESCRIBER INFORMATION         Prescriber's Name:			Alternate Phone:	
PRESCRIBER INFORMATION         Prescriber's Name:				
Prescriber's Name:	_	•	· · · · · · · · · · · · · · · · · · ·	
NPI #:DEA #:Group or Hospital:				
Address:	Prescriber's Nam	ne:	State License #:	
INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and base of 20 prescription and insurance cards with this form, if available (front and base of 210 mg once monthly for 12 doses   INSURANCE 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: Ib/kg   Height: in/cm   PRESCRIPTION INFORMATION   MEDICATION   STRENGTH   Administer two consecutive subcutaneous injections (105 mg each) for a total dose of 210 mg once monthly for 12 doses   Quantity:   600 mcg/2.4 mL				
INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and base of 20 prescription and insurance cards with this form, if available (front and base of 210 mg once monthly for 12 doses   INSURANCE 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: Ib/kg   Height: in/cm   PRESCRIPTION INFORMATION   MEDICATION   STRENGTH   Administer two consecutive subcutaneous injections (105 mg each) for a total dose of 210 mg once monthly for 12 doses   Quantity:   600 mcg/2.4 mL	Address:		City, State, ZIP Code:	
DIAGNOSIS AND CLINICAL INFORMATION         Needs by Date:				
Needs by Date:		E INFORMATION	Please fax copy of prescription and insurance cards with this for	m, if available (front and back)
Needs by Date:	DIAGNOSIS	SAND CLINICAL	INFORMATION	
Diagnosis (ICD-10):         M80.0 Age related osteoporosis with current pathological fracture         M81.0 Age Related osteoporosis without current pathological fracture         Other Code:				
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   SPRESCRIPTION INFORMATION   MEDICATION   STRENGTH   DOSE & DIRECTIONS   QUANTITY/REFILLS   Levenity   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: 1 device (28-day support)				_
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   Levenity   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 support)			ith current pathological fracture	
Other Code: Description   Patient Clinical Information:   Allergies:   Weight:   Lb/kg   Height:   MEDICATION INFORMATION   MEDICATION   STRENGTH   DOSE & DIRECTIONS   QUANTITY/REFILLS   Administer two consecutive subcutaneous injections (105 mg each) for a total dose of 210 mg once monthly for 12 doses   Quantity:   2 syringes   Refills:   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:   Quantity:   1 device (28-day support)	= *			
Patient Clinical Information: Allergies: Weight:lb/kg Height:in/cm         DRESCRIPTION INFORMATION       DOSE & DIRECTIONS       QUANTITY/REFILLS         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         600 mcg/2.4 mL       600 mcg/2.4 mL       Quantity: 2 syringes each support       Quantity: 2 syringes each support				
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         600 mcg/2.4 mL       600 mcg/2.4 mL       Quantity:       Quantity:				
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         600 mcg/2.4 mL       600 mcg/2.4 mL       Quantity:       Quantity:	Allergies:		lb/kg Height:lb/kg Height:in/	/cm
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         600 mcg/2.4 mL       600 mcg/2.4 mL       Quantity:       Quantity:	<b>5</b> PRESCRIPT	ION INFORMATI	ON	
L Evenity       105 mg/1.17 mL       each) for a total dose of 210 mg once monthly for 12 doses       Refills: 11				<b>QUANTITY/REFILLS</b>
600 mcg/2.4 mL 1 device (28-day supp	<b>Evenity</b>	105 mg/1.17 mL	Administer two consecutive subcutaneous injections (105 mg	
600 mcg/2.4 mL		C C	, , , , ,	Quantity: 2 syringes
			, , , , ,	Quantity: 2 syringes Refills: 11
			, , , , ,	Quantity: 2 syringes Refills: 11 Quantity:
Delivery Device supply)		600 mcg/2.4 mL	each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply)
		600 mcg/2.4 mL (250mcg/mL)	each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day
31G Pen Needles: Quantity:		600 mcg/2.4 mL	each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply)
<b>5</b> mm		600 mcg/2.4 mL (250mcg/mL) Delivery Device	each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills:
	Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles:	each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity:
8 mm Refills:		600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles:	each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity: 28-day supply
Prolia 60 mg lpiect 60 mg subcutaneously every 6 months Quantity:	Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles: 5 mm 6 mm	each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity: 28-day supply 84-day supply
Reflux.	Forteo Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles: 5 mm 6 mm 8 mm	each) for a total dose of 210 mg once monthly for 12 doses Inject 20 mcg (0.08 mL) subcutaneously once daily. Use with Forteo delivery device as directed.	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity: 28-day supply 84-day supply Refills: Quantity:
	Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles: 5 mm 6 mm	each) for a total dose of 210 mg once monthly for 12 doses Inject 20 mcg (0.08 mL) subcutaneously once daily. Use with Forteo delivery device as directed. Inject 60 mg subcutaneously every 6 months.	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity: 28-day supply 84-day supply Refills:
Reclast 5 mg influse 5 mg iv once every 2 years over no less than 15 Refills:	Forteo Forteo Prolia	600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles: 5 mm 6 mm 8 mm 60 mg	<ul> <li>each) for a total dose of 210 mg once monthly for 12 doses</li> <li>Inject 20 mcg (0.08 mL) subcutaneously once daily.</li> <li>Use with Forteo delivery device as directed.</li> <li>Inject 60 mg subcutaneously every 6 months.</li> <li>Infuse 5 mg IV once a year over no less than 15 minutes.</li> </ul>	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity: 28-day supply 84-day supply Refills: Quantity: Refills:
minutes.	Forteo Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles: 5 mm 6 mm 8 mm	<ul> <li>each) for a total dose of 210 mg once monthly for 12 doses</li> <li>Inject 20 mcg (0.08 mL) subcutaneously once daily.</li> <li>Use with Forteo delivery device as directed.</li> <li>Inject 60 mg subcutaneously every 6 months.</li> <li>Infuse 5 mg IV once a year over no less than 15 minutes.</li> <li>Infuse 5 mg IV once every 2 years over no less than 15</li> </ul>	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity: 28-day supply 84-day supply Refills: Quantity: Refills: Quantity: Quantity: 1 vial
Patient is interested in patient support programs     STAMP SIGNATURE NOT ALLOWED     Ancillary supplies and kits provided as needed for adminis     PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)	Forteo Forteo Prolia Reclast	600 mcg/2.4 mL (250mcg/mL) Delivery Device 31G Pen Needles: 5 mm 6 mm 8 mm 60 mg 5 mg	<ul> <li>each) for a total dose of 210 mg once monthly for 12 doses</li> <li>Inject 20 mcg (0.08 mL) subcutaneously once daily.</li> <li>Use with Forteo delivery device as directed.</li> <li>Inject 60 mg subcutaneously every 6 months.</li> <li>Infuse 5 mg IV once a year over no less than 15 minutes.</li> <li>Infuse 5 mg IV once every 2 years over no less than 15 minutes.</li> </ul>	Quantity: 2 syringes Refills: 11 Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills: Quantity: 28-day supply 84-day supply Refills: Quantity: Quantity: Quantity: Refills: Quantity: 1 vial Refills: 

"Dispense As Written" / Brand Medically Necessary / Do DAW / May Not Substitute <b>Prescriber's Signature:</b>	Not Substitute / No Substitution /Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:Date:	
CA, MA, NC & PR: Interchange is mandated unless Prescribe	r writes the words " <b>No Substitution</b> "	ATTN: New York and Iowa provide	rs, 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)

		Complete Patient and Prescriber Information						
		Patient DOB:Patient F	Phone:					
Prescriber Name:								
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:	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:		Prescriber's Signature:	Date:
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution	on"	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.

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.