

MEDICAL ASSESSMENT

OSTEOPOROSIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.WellDyneSpecialty.com To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

Patient:	ent:Caregiver:										
DOB:	Male	Female	Weight:	kgs or	lbs (check one)	Height:	in or	cm (check one)	Recorded Date: _		
Address:					City:			State:	Zip:		
Best Phone #:	st Phone #: Cell Alternate Phone #:						Cell	Email:			
Allergies:									Latex Allergy:	Yes	No
ICD-10 Code for requested therapy:				ICD-10 Co	ICD-10 Code(s) for other medical conditions:						

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Prior (FAILED) Therapy:								
Therapy	Date(s)			Therapy	Date(s)			
Fosamax				Prolla				
Actonel				Reclast				
Forteo				Boniva				
Other (please list):								
Date of Diagnosis:			_ BMD/T-Score:	Is patient new to therapy?	Yes No			
History of osteoporotic fracture?	? Yes	No						
If no, is patient at high risk?	Yes	No						
If yes, date of fracture:		Loc	ation of fracture:					

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

	MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
KMALION	Forteo [®] New Start? Y N Date therapy started:	600mcg/2.4mL Pen	Inject 1 dose (20mcg) Sub-Q every day. Discard device 28 days after first use. To be administered by a health care professional.	1 Pen (4-week supply) 3 Pens (12-week supply)	
INFORM	Prolia®	60mg/1mL PFS	Inject the contents of 1 syringe (60mg) Sub-Q every 6 months.	1 Prefilled Syringe	
	Reclast®	5mg/100mL Vial	Infuse 5mg IV over no less than 15 minutes once annually. To be administered by a health care professional.	One: 5mg/100mL Vial	0
PRESCRIP	Boniva®	3mg/3mL PFS	Inject the contents of 1 syringe (3mg) IV every 3 months. To be administered by a health care professional.	One: 3mg/3mL PFS	
	Other				

INJECTION TRAINING:		OFFICE TO COORDINA	TE WEI	LDYNE SPECIALTY TO COORDIN	CIALTY TO COORDINATE			
Anticipate	d Start Date:			Prescrib	er Specialty:			_
Ship to:	Patient	Physician	Clinic	Other:				-
Fax #:								_
Office Add	dress:				City:	State:	Zip:	_
The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.								э.
The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.								
I understand that WellDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.								
Prescribe	r's Name:			Prescriber	s Signature:		Date:	-
Use su	bstitution	Dispense as w	ritten					

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