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 INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

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: _____ Location of fracture: _____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ 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)	_____
☐ 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
☐ 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				

PRESCRIBER INFORMATION

INJECTION TRAINING: OFFICE TO COORDINATE WELLDYNE SPECIALTY TO COORDINATE

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ 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.

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.

Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written