APEX SPECIALTY PHARMACY

OSTEOPOROSIS

Benefit Investigation + Prior Authorization Support

Date _____

Ship to:: ☐ Patient ☐ Provider

PATIENT INFORMATION::

Patient Name:		Prescriber:	
Street Address:		NPI:	
City, State, Zip:		Group:	
Phone #1:		Street Address:	
Phone #2:		City, State, Zip:	
Social Security:		Office Phone:	
Date of Birth:	/ /	Office FAX:	
Sex:	☐ M ☐ F	Primary Contact:	

PLEASE SEND INSURANCE CARD AND DEMOGRAPHIC INFORMATION

DIAGNOSIS (ICD-10 // ICD-9)

☐ M81. ____ // 733.00 Osteoporosis

☐ Other _____

Please send T-Score, DEXA and Fracture History

CURRENT / PREVIOUS THERAPIES FOR THIS CONDITION::

ALLERGIES / SENSITIVITIES::

PRESCRIPTION INFORMATION::

Medication	Dosage	Dosing Instructions	Refill
☐ Boniva	☐ 3mg /ml	☐ Inject 3mg every 3 months	
☐ Forteo	☐ 600mg / 2.4ml	☐ Inject 20mcg SC daily ☐ Needles :: Ultra Fine 31 gauge _____ qty (box of 100)	
☐ Prolia	☐ 60mg PFS	☐ Inject 60mg SC every 6 months	
☐ Reclast	☐ 5mg / 100ml		
☐ Tymlos	☐ 80mcg PEN	☐ Inject 80mcg SC daily	
☐			

PRESCRIBER SIGNATURE _____ _____ DATE ____ / ____ / ____

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Phone: 855.257.2584 || Fax: 866.680.3539