

Date: _____ Auth #: _____ Auth Dates: _____ UPMC prior auth form attached

Patient Information

First Name: _____ Last Name: _____ DOB: _____ SSN: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alternate Phone: _____ Caregiver/ Emergency Contact: _____ Phone: _____
 Weight: _____ Allergies: _____ Latex Allergy: Yes No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
 Insured: _____ Insured: _____
 Phone: _____ Phone: _____
 Policy #: _____ Group #: _____ Policy #: _____ Group #: _____

ICD 10

Diagnosis:
 M81.0 Generalized Osteoporosis M81.0 Postmenopausal Osteoporosis Other: _____
 M81.8 NEC Osteoporosis M81.8 Idiopathic Osteoporosis

Prescription Information

Medication	Dose/ Strength	Directions	Quantity	Refills
<input type="checkbox"/> Boniva®	<input type="checkbox"/> 3mg PFS	<input type="checkbox"/> IV every 3 months	1 PFS	
<input type="checkbox"/> Evenity®	<input type="checkbox"/> 105mg/1.17ml PFS	Administer 210mg (2 syringes) subcutaneously once every month for 12 doses in the abdomen, thigh, or upper arm		
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 250mcg/ml Needle: <input type="checkbox"/> 32ga <input type="checkbox"/> 30/31ga	<input type="checkbox"/> Inject 20mcg SC once daily	<input type="checkbox"/> 28 day supply	
<input type="checkbox"/> Prolia®	<input type="checkbox"/> 60mg/1ml PFS	<input type="checkbox"/> Inject 60mg SC every 6 months	1	
<input type="checkbox"/> Reclast®	<input type="checkbox"/> 5mg/100ml	<input type="checkbox"/> Infuse 5mg IV over 15-20 minutes annually	1	
<input type="checkbox"/> Teriparatide	<input type="checkbox"/> 250mcg/ml Needle: <input type="checkbox"/> 32ga <input type="checkbox"/> 30/31ga	<input type="checkbox"/> Inject 20mcg SC once daily	<input type="checkbox"/> 28 day supply	
<input type="checkbox"/> Tymlos™	<input type="checkbox"/> 3120mcg/1.56 ml pen <input type="checkbox"/> Needle: 31ga	<input type="checkbox"/> Inject 80mcg SC once daily	1	

Prescriber Information

Date Shipment Needed: _____ Ship to: Patient Physician/ Clinic Other: _____
 Physician's Name: _____ Office Contact Name: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Physician's Signature: _____ Date: _____