Cosentino's SPECIALTY CARE

OSTEOPOROSIS SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ______________________

Address: ______________________

City: ______________ State: ____ Zip: __________

Phone: ______________ Alt. Phone: ______________

Email: ______________________

DOB: __________ Gender: ❍ M ❍ F Caregiver: __________

Height: ______ Weight: ______ Allergies: __________

2 PRESCRIBER INFORMATION:

Name: ______________________

Address: ______________________

City: ______________ State: ____ Zip: __________

Phone: ______________ Fax: ______________

NPI: ______________ DEA: ______________

Tax I.D.: ______________________

Office Contact: ______________ Phone: ______________

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3 STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: ______________ ICD-10: ______________

Is patient new to therapy? ❑ Yes ❑ No Is patient continuing therapy? ❑ Yes ❑ No

Date therapy started: ______________ Date of last injection: ______________

Is patient high risk for fracture? ❑ Yes ❑ No History of osteoporotic fracture? ❑ Yes ❑ No

If Yes, Location of Fracture: ______________ Date of Fracture: ______________

BMD/T-Score: ________ Date: ________ FRAX Score: ________ Date: ________

Contraindication(s) to bisphosphonate therapy? ❑ No ❑ Yes

If Yes: ❑ Dysphagia ❑ GERD ❑ Ulcer ❑ Other ______________

Please Attach All Medical Documentation Including:

❑ DEXA Scan ❑ Medication History ❑ CMP Panel ❑ Other Information Pertinent to the Case

Labs: Calcium: ________ Vitamin D: ________ Date: ________

Is patient currently taking Calcium and Vitamin D supplements? ❑ Yes ❑ No

Has patient had a myocardial infarction or stroke within the preceding year? ❑ Yes ❑ No

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:	Length of Treatment:
❑ Actonel®	________
❑ Boniva®	________
❑ Forteo®	________
❑ Fosamax®	________
❑ Prolia®	________
❑ Reclast®	________
❑ Other	________

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: ______________________ Patient's Date of Birth: ______________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ BONSITY	❑ 620 mcg/2.48 mL (250 mcg/mL) Pen	❑ Inject 20mcg subcutaneously daily	1	
❑ PEN NEEDLES	❑ 29 Gauge ❑ 30 Gauge ❑ 31 Gauge ❑ 5 mm		100	
❑ EVENITY™	❑ 105mg/1.17ml Prefilled Syringe	❑ Inject 210mg SC (two 105mg injections, one after the other) by a healthcare provider, every month for 12 months in the abdomen, thigh, or upper arm.	2	
❑ FORTEO®	❑ 600mcg/2.4ml Pen	❑ Inject 20mcg subcutaneously once daily	1	
❑ PEN NEEDLES	❑ 31 Gauge ❑ 5mm		100	
❑ PROLIA®	❑ 60mg/ml Prefilled Syringe	❑ Inject 60mg subcutaneously every 6 months	1	
❑ ________	________	________		

PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______________ Date: ________
Substitution Permitted

Signature: ______________ Date: ________
Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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