# Forteo Enrollment Form

CVS specialty®

**Fax Referral To:** 1-877-232-5455
**Address:** 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

**Phone:** 1-800-896-1464

**Six Simple Steps to Submitting a Referral**

## 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
*Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*
Primary Phone: _____ Alternate Phone: _____DOB: _____ Gender: ☐ Male ☐ Female
Email: _____Last Four of SSN: _____Primary Language: _____

## 2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax_____ Contact Person: _____ Contact's Phone: _____

## 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

## 4 DIAGNOSIS AND CLINICAL INFORMATION

**Diagnosis (ICD-10):**

☐ M81.00 age-related osteoporosis without current pathological fracture
☐ M81.8 other osteoporosis without current pathological fracture
☐ M81.6 localized osteoporosis
☐ Other Code: _____ Description: _____

**Patient Clinical Information:**

Allergies: _____ Height: _____in/cm Weight: _____lb/kg
Needs by Date: _____Ship to: ☐ Patient ☐ Office ☐ Other: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Forteo | 600 mcg/2.4 ml Delivery Device | Inject 20 ug (0.08 ml) subcutaneous once daily. | Quantity:<br>☐ 1 device (28-day supply)<br>☐ 3 devices (84-day supply)<br>Refills: _____ |
| ☐ Forteo | NEEDLES 31 gauge:<br>☐ 5 mm ☐ 6 mm<br>☐ 8 mm | Use with Forteo Delivery Device as directed. | Quantity:<br>☐ 4-week supply<br>☐ 12-week supply<br>Refills: _____ |
| ☐ Other: _____ | Other: _____ | Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Other: _____ | Other: _____ | Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Other: _____ | Other: _____ | Other: _____ | Quantity: _____<br>Refills: _____ |

☐ Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

## 6 PHYSICIAN SIGNATURE REQUIRED

DISPENSE AS WRITTEN (Date)
X_____

PRODUCT SUBSTITUTION PERMITTED (Date)
X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.