

Osteoporosis Enrollment Form

Medications A-S

(Evenity, Forteo, Prolia, Reclast)



Fax Referral To: 1-888-280-1191 OR 787-759-4161
 Phone: 1-888-280-1190 OR 787-759-4162
 Email Referral To: Customer.ServiceFax@CVSHealth.com
 Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Address: _____ City, State, ZIP Code: _____
 Gender: Male Female
 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: _____
 If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
 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

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

- M80.0 Age related osteoporosis with current pathological fracture
 M81.0 Age Related osteoporosis without current pathological fracture
 Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Evenity	105 mg/1.17 mL	Administer two consecutive subcutaneous injections (105 mg each) for a total dose of 210 mg once monthly for 12 doses	Quantity: 2 syringes Refills: 11
<input type="checkbox"/> Forteo	600 mcg/2.4 mL (250mcg/mL) Delivery Device	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: <input type="checkbox"/> 1 device (28-day supply) <input type="checkbox"/> 3 devices (84-day supply) Refills: _____
<input type="checkbox"/> Forteo	31G Pen Needles: <input type="checkbox"/> 5 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 8 mm	Use with Forteo delivery device as directed.	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply Refills: _____
<input type="checkbox"/> Prolia	60 mg	Inject 60 mg subcutaneously every 6 months.	Quantity: _____ Refills: _____
<input type="checkbox"/> Reclast	5 mg	<input type="checkbox"/> Infuse 5 mg IV once a year over no less than 15 minutes. <input type="checkbox"/> Infuse 5 mg IV once every 2 years over no less than 15 minutes.	Quantity: 1 vial Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

<p><small>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</small></p> <p>Prescriber's Signature: _____ Date: _____</p>	<p><small>May Substitute / Product Selection Permitted / Substitution Permissible</small></p> <p>Prescriber's Signature: _____ Date: _____</p>
<p>CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription</p>	

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.

Osteoporosis Enrollment Form

Medications T-Z

(Teriparatide, Tymlos)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Teriparatide Injection* <i>(*FDA approved treatment alternative to Forteo-Not automatically substituted for Forteo)</i>	620 mcg/2.48 mL (250 mcg/mL) Delivery Device	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: <input type="checkbox"/> 1 device (28-day supply) <input type="checkbox"/> 3 devices (84-day supply) Refills: _____
<input type="checkbox"/> Teriparatide	31G Pen Needles: <input type="checkbox"/> 5 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 8 mm	Use with Teriparatide Delivery Device as directed.	Quantity: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply Refills: _____
<input type="checkbox"/> Tymlos	3120 mcg/1.56 mL	Inject 80 mcg (0.04 mL) subcutaneously once daily.	Quantity: <input type="checkbox"/> 1 device (30-day supply) <input type="checkbox"/> 3 devices (90-day supply) Refills: _____
<input type="checkbox"/> Tymlos	31G Pen Needles: <input type="checkbox"/> 5 mm <input type="checkbox"/> 6 mm <input type="checkbox"/> 8 mm	Use with Tymlos delivery device as directed.	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: _____ Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

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.

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