SMP PHARMACY SOLUTIONS

Fax#: 855.447.6637
Ph#: 855.650.5009

Osteoporosis Prescription Faxable

Today's Date: _____ Needed by: _____ Name: _____ Phone: _____

Patient Demographic: (Provide the following or attached demographic sheet)

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Alt. Phone: _____

SS#: _____ Date Birth: _____

Gender: _____ Height: _____ Weight _____ BSA _____ m2

Prescriber: (Provide as much information as possible)

Prescriber's Name: _____ Group/Hospital: _____

Specialty: _____ NPI #: _____ DEA: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Alt. Contact Name: _____

Phone: _____ Position: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card):

Primary Insurance Name: _____ ID# _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____

☐ No Insurance ☐ Patient will pay out of pocket ☐ Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):

☐ Patient Address ☐ First Fill Physician's Office, Refill to Patient Address ☐ Patient will pick up at Pharmacy

Diagnosis (ICD -10 code):

☐ M80.0 Osteoporosis with Pathological fracture ☐ M85.9 Osteoporosis ☐ M81.0 Age-related osteoporosis without current pathological fracture

Injection Training & Educational Needs: ☐ Specialty Pharmacy Injection Training Requested ☐ Manufacturer's Patient Assistance Program Enrollment Requested OR (Please Choose only one) ☐ Physician's Office already trained Patient ☐ Patient is already independently Injecting

Patient Allergies/ Allergic reactions:

1. _____

2.

Prior (Failed) Medications (Reason for D/C):

1. _____

2.

Clinical Information – Statement of Medical Necessity:

Diagnosis (include ICD-10 code if available) _____

Drug Allergies _____ T-Score _____ Type _____ Date ____/____/____

Fracture History: Site _____ Date ____/____/____ Site _____ Date ____/____/____

Medication	Dose	Direction	Quantity	Refills
☐ Forteo Pen	600mcg/2.4ml	Inject 20mcg SC once daily		
☐ Tymlos Pen	3120mcg/1.56mL	Inject 80mcg SC daily		
		☐ Pen Needles ☐ Sharps ☐ Alcohol Swabs		
☐ Prolia *	60mg PFS	Inject 60mg SC every 6 months		
☐ Reclast *	5mg/100ml	Inject 100mg IV once a year		
☐ Other				

By signing this form and utilizing our services, you are authorizing SMP and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ ____/____/____

Prescriber Signature Date