USspecialty™
powered by WellDyne

OSTEOPOROSIS ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.usspecialtycare.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient:______________________________ Caregiver: ______________________

DOB:________ ☐ Male ☐ Female Weight:______ ☐ kgs or ☐ lbs (check one) Height______ ☐ in or ☐ cm (check one) Recorded Date: ___________

Address:______________________________ City: ______________ State: ______ Zip: ___________

Best Phone #:__________________ ☐ Cell Alternate Phone #:__________________ ☐ Cell Email:__________________

Allergies:______________________________ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: ______________________ ICD-10 Code(s) for other medical conditions: ______________________

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Prior (FAILED) Therapy:

Therapy	Date(s)	Therapy	Date(s)
☐ Fosamax	__________________	☐ Prolia	__________________
☐ Actonel	__________________	☐ Reclast	__________________
☐ Forteo	__________________	☐ Boniva	__________________

☐ Other (please list): ____

Date of Diagnosis:______________________ BMD/T-Score:__________________ Is patient new to therapy? ☐ Yes ☐ No

History of osteoporotic fracture? ☐ Yes ☐ No

If no, is patient at high risk? ☐ Yes ☐ No

If yes, date of fracture: __________________ Location of fracture: ______________________________

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Forteo® New Start? ☐ Y ☐ N Date therapy started: __________	☐ 600mcg/2.4mL Pen	☐ Inject 1 dose (20mcg) Sub-Q every day. Discard device 28 days after first use. To be administered by a health care professional.	☐ 1 Pen (4-week supply) ☐ 3 Pens (12-week supply)	_____
☐ Prolia®	☐ 60mg/1mL PFS	☐ Inject the contents of 1 syringe (60mg) Sub-Q every 6 months.	☐ 1 Prefilled Syringe	_____
☐ Reclast®	☐ 5mg/100mL Vial	☐ Infuse 5mg IV over no less than 15 minutes once annually. To be administered by a health care professional.	☐ One: 5mg/100mL Vial	0
☐ Boniva®	☐ 3mg/3mL PFS	☐ Inject the contents of 1 syringe (3mg) IV every 3 months. To be administered by a health care professional.	☐ One: 3mg/3mL PFS	_____
☐ Other				

INJECTION TRAINING: ☐ **OFFICE TO COORDINATE** ☐ **USSC TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: ______________________ Prescriber Specialty: ______________________________

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:______________________________

Fax #: ______________________Contact Name: ______________________________

Office Address: ______________________________ City: ______________________ State:_____ Zip:________

The terms and conditions posted at www.usspecialtycare.com have been read by the person signing this form and are incorporated into this document by reference.
The data privacy terms posted at www.usspecialtycare.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that USSC may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: __________________________Prescriber's Signature: __________________________Date: ___________

☐ Use substitution ☐ Dispense as Written

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