

Ship To: Patient Physician/Clinic Date Shipment Needed: _____ Rx: New Refill _____

PATIENT INFORMATION	Patient's Full Name: _____	PATIENT MEDICAL HISTORY	ICD-9 Code: _____
	Address: _____		Date of Osteoporosis Diagnosis: _____
	City, State, Zip: _____	DEXA T-score (worst sites): _____	
	Home Phone: _____	Previous Fracture(s): <input type="checkbox"/> Yes or <input type="checkbox"/> No	
	Alt. Phone: _____	Site of Fracture(s): _____	
	Patient SS#: _____	Others: _____	
	DOB: _____	Prior Failed Medications	Duration
	Allergies: _____	Fosamax (alendronate) _____	_____
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Actonel (risdrionate) _____	_____
	Primary Insurance: _____	Miacalcin Nasal Spray _____	_____
ID#: _____ Phone: _____	Evista (raloxifene) _____	_____	
Secondary Insurance: _____	Boniva _____	_____	
ID#: _____ Phone: _____	Reclast _____	_____	
PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)			

If known, provide T-score BEFORE & AFTER treatment with above listed medication(s)

T-Score at Baseline (with date): _____
 T-Score After (with date): _____
 Is patient unable to tolerate bisphosphonoates (alendronate or risronate)? _____

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
Forteo	<input type="checkbox"/> 600 mcg/2.4ml PFS	<input type="checkbox"/> Inject 20mcg SC as directed ONCE a day		
Pen Needles	<input type="checkbox"/> 31 gauge <input type="checkbox"/> 4mm <input type="checkbox"/> 5mm <input type="checkbox"/> 6mm			
Prolia	<input type="checkbox"/> 60 mg Prefilled Syringe	<input type="checkbox"/> Inject 60mg SC ONCE every 6 months at MD Office		
Reclast	<input type="checkbox"/> 5 mg / 100 ml	<input type="checkbox"/> Infuse 5 mg IV every 12 months		
Bonvia	<input type="checkbox"/> 3 mg / 3 ml	<input type="checkbox"/> Infuse 3 mg IV every 3 months		

PRESCRIBER INFORMATION	Physician's Name (Please Print): _____	NPI#: _____
	Address: _____	License#: _____
	City, State, Zip: _____	DEA#: _____
	Phone: _____ Fax: _____	Contact Name: _____
	Physician's Signature: _____	Date: _____

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.