Enexia Specialty

Forteo Prescription

Fax Referral to 718-360-9655
Or Call : 718-556-0942

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Best Phone Number: _____ Alternate Phone Number: _____
DOB: _____ Weight: _____ kgs. or lbs. (circle one) Recorded Date: _____
Caregiver: _____ Allergies: _____

Insurance Information

Fill out entirely OR (fax copy of patient's insurance card - both sides)

Primary Insurance: _____ Secondary Insurance: _____
Insured: _____ Insured: _____
Phone: _____ Phone: _____
Policy #: _____ Policy #: _____
RxBIN: _____ RxPCN: _____ RxBIN: _____ RxPCN: _____

Clinical Information

DIAGNOSIS:

- ☐ Z79.51 Long-term (current) use of steroids
- ☐ M81.0 Osteoporosis, postmenopausal
- ☐ M81.8 Osteoporosis, drug induced
- ☐ M84.48XA Osteoporosis, fracture of the vertebrae
- ☐ M84.40XA Osteoporosis, unspecified fracture
- ☐ M89.9 Disorder of bone, unspecified
- ☐ M84.459A Osteoporosis, fracture of neck of Femur
- ☐ M94.9 Disorder of cartilage, unspecified

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: _____
Previous Osteoporotic treatment:

DRUG	TRIAL DATE	THERAPEUTIC OUTCOME
☐ Fosamax	_____	_____
☐ Actonel	_____	_____
☐	_____	_____

Prescriptions

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ FORTEO	2.4 ml	Inject 20mcg SC QD as directed	☐ 1 pen *(4 week supply)* ☐ 3 pens *(12 week supply)*	_____
☐ PEN NEEDLES 31 gauge	5 mm	Use Forteo Pen as directed	_____	_____
☐ _____	_____	_____	_____	_____

Injection Training

- ☐ Patient has received pen and injection training
- ☐ Physician's office to provide injection training
- ☐ Nate's Pharmacy to coordinate injection training

Prescriber Information

Date Shipment Needed: _____ Ship to: _____ Patient _____ Physician/Clinic
Ship to Other: _____
Physician's Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #: _____ NPI #: _____
OfficeAddress: _____ City,State,Zip: _____

I authorize Vitacare and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature: _____