# OSTEOPOROSIS **ENROLLMENT FORM**

GREENHILL PLUS+
Specialty Pharmacy Solution
Connection • Care • Community

***PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396***

**Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805**

## Patient Information

Patient Name _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ SSN _____ Gender ○ M ○ F
Weight _____kg/lbs Height _____cm/in BSA _____$m^2$
Language Preference: ○ English ○ Spanish ○ Other _____
Caregiver Name _____ Relation _____
Local Pharmacy _____ Phone _____
Insurance Plan _____ Plan ID _____
Prior Authorization Reference Number _____
*Please fax a copy of front and back of the insurance card(s)*

## Prescriber Information & Shipping Information

Prescriber's Name _____
DEA _____
NPI _____
Group/ Hospital _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Contact _____
Phone _____ Alternate Phone _____
Fax _____
Email _____
If shipping to prescriber ○ First Fill ○ Always ○ Never

## Medical Information (Section must be completed to process prescription) (Attach separate sheet if needed)

*Diagnosis- Please include diagnosis name with ICD-10 code*
○ ICD-10 _____ Description _____

***Disease State Description***
○ Postmenopausal osteoporosis with high fracture risk (female)
○ Postmenopausal osteoporosis prophylaxis
○ Hypogonadal osteoporosis with high fracture risk (male)
○ Glucocorticoid-induced osteoporosis treatment / prophylaxis
○ Paget's disease
○ Other _____
Date of Diagnosis _____

| **Test Results** | **WNL** | |
|---|---|---|
| ○ Serum calcium _____ | ○ Yes | ○ No |
| ○ SCr / CrCl _____ | ○ Yes | ○ No |
| ○ BMD _____ | ○ Yes | ○ No |
| ○ T Score _____ | ○ Yes | ○ No |

**Additional Information**
Therapy ○ New ○ Reauthorization ○ Restart
Allergies _____
Fracture History _____

Prior Failed Therapies
○ Actonel®(risedronate) ○ Boniva® (ibandronate)
○ Fosamax® (alendronate) ○ Prolia® (denosumab)
○ Reclast® (Zoledronic Acid Injection)
Concomitant Medications _____
Additional Comments _____
Treatment Start Date _____ Treatment End Date _____

## Prescription Information

| Drugs | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ○ **Boniva® Injection** | | | | |
| ○ **Forteo®** | | | | |
| ○ **Prolia®** | | | | |
| ○ **Reclast®** | | | | |
| ○ **Tymlos®** | | | | |

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

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

***Prescriber's Signature:*** _____ _____ ***Date:*** _____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

***Supervising Physician / Supervising Physician Signature:*** _____