BROADWAY SPECIALTY PHARMACY

OSTEOPOROSIS

Fax: 833.803.3110
Phone: 800.640.8207
broadwayrx.health

1. PATIENT

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK

NAME:		ADDRESS:	CITY:	STATE:	ZIP:
DOB:	SEX: ☐ F ☐ M	PHONE:	CELL PHONE:	SSN:	
HEIGHT:	WEIGHT:	HIPAA CONTACT/CAREGIVER:	ALLERGIES: ☐ LATEX ☐ NKDA		

2. CLINICAL INFORMATION

DATE OF DIAGNOSIS: __________ HISTORY: ☐ NEW ☐ RESTART ☐ CONTINUING

DIAGNOSIS / ICD-10: ☐ AGE-RELATED OSTEOPOROSIS W/O FRACTURE (M81.0) ☐ AGE-RELATED OSTEOPOROSIS W/FRACTURE (M80.0) ☐ OTHER:

BONE DENSITY T-SCORE: __________ DATE:__________ | FRAX SCORE: __________ DATE: __________ | LABS: CALCIUM: __________ VITAMIN D: __________ DATE: ________

HISTORY OF FRACTURE: ☐ NO ☐ YES - SITE:__________ DATE:__________ | IS PATIENT HIGH RISK FOR FRACTURE? ☐ YES ☐ NO

CONTRAINDICATION(S) TO BISPHOSPHONATE THERAPY? ☐ NO ☐ YES – IF YES: ☐ DYSPHAGIA ☐ GERD ☐ ULCER ☐ OTHER________________

FAILED TREATMENTS: ** ENTER LENGTH OF TREATMENT AND DATES BELOW/BESIDE FAILED THERAPY ** | CURRENT THERAPY:

☐ ACTONEL __________ ☐ BONIVA __________ ☐ FORTEO __________ ☐ FOSAMAX __________ ☐ PROLIA __________ ☐ RECLAST __________ ☐ TYMLOS __________ ☐ OTHER__________________ __________

** PLEASE ATTACH CHART NOTES/LABS (FOLLOWING ARE MOST IMPORTANT): ☐ DEXA SCAN ☐ MEDICATION HISTORY ☐ CMP PANEL ☐ OTHER INFORMATION PERTINENT TO CASE **

NOTES:

3. Rx

IF SHIPPING TO PRESCRIBER: NEXT APPT DATE: _________ ☐ FIRST FILL ☐ ALL FILLS | **PATIENT RECEIVED STARTER DOSE:** ☐ YES: DATE _________ ☐ NO

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ FORTEO®	o 20mcg/2.4ml Prefilled Pen	o Inject 20mcg Sub-Q once daily	1	__________
☐ PROLIA®	o 60mg/ml PFS	o Inject 60mg Sub-Q every 6 months	1	__________
☐ TYMLOS®	o 80mcg/ml Prefilled Pen	o Inject 80mcg Sub-Q once daily	1	__________
☐ PEN NEEDLE	o 5mm o 6mm o 8mm	o Use with pen device as directed	1 Box	__________
☐				
☐				

4. PRESCRIBER INFORMATION

UPON PA DENIAL: ☐ SEND FORMULARY ALTERNATIVES ☐ DRAFT APPEAL | **INJECTION TRAINING:** ☐ PHARMACY TRAIN/ADMINISTER ☐ PRESCRIBER

PRESCRIBER SIGNATURE: I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing Broadway Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-Pay Assistance/Foundations.

Signature: ____ Date:____________________ Signature:____Date: _____________
Substitution Permitted   Dispense As Written

PRESCRIBER NAME:	ADDRESS:		CITY:	STATE:	ZIP:
OFFICE CONTACT:	PHONE:	FAX:	NPI:	DEA:	

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