BioPlus® Specialty Pharmacy
A Carelon Company

Skip this form & e-prescribe! Select BioPlus from your EHR

OSTEOPOROSIS

Fax: 800-269-5493
Phone: 888-292-0744
bioplusrx.com

PATIENT INFORMATION

Name:		SSN:	DOB:
Address:	City:	State:	ZIP:
Home Phone:	Cell:	Email:	Gender: ○ Female ○ Male

CLINICAL INFORMATION

Primary Diagnosis: ICD-10 _____ Description: _____ Secondary Diagnosis: ICD-10 _____ Description: _____

Prior Treatment ☐ Fosamax *(alendronate)* Duration: _____ ☐ Boniva *(ibandronate)* Duration: _____ ☐ Atelvia *(risedronate)* Duration: _____

Allergies: _____ Height: _____ Weight: _____

Bone Density Test? T-Score: _____ Type: _____

Fracture history, if yes which site: _____

Has patient been on Forteo before? ☐ Yes ☐ No If yes, how long _____

INSURANCE INFORMATON (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

MEDICATION	STRENGTH	DIRECTIONS	QUANITY	REFILLS
☐ **FORTEO®** *(teriparatide)*	600 mcg/2.4 mL pen	Inject 20 mcg SUBQ as directied once daily.	28 day supply	
	31 Guage pen ☐ 5 mm ☐ 6 mm ☐ 8 mm	Use with Forteo delivery device as directed.	1 device (28-day supply)	
☐ **BONIVA®** *(ibandronate)*	3 mg/3 mL PFS	Infuse 3 mg IV over a period of 15 to 30 seconds every 3 months.	1 dose	
☐ **PROLIA®** *(denosumab)*	60 mg/1 mL PFS	Inject 60 mg SUBQ every 6 months.	1 dose	
☐ **RECLAST®** *(zoledronic acid)*	5 mg/100 mL solution	☐ Infuse 5 mg IV once a year over no less than 15 minutes. ☐ Infuse 5 mg IV once every 2 years over no less than 15 minutes.	1 vial	
☐ **TYMLOS®** *(abaloparatide)*	3120 mcg/1.56 mL pen	Inject 80 mcg (0.4 mL) SUBQ once daily.	30-day supply	
	31 Gauge pen ☐ 5 mm ☐ 6 mm ☐ 8mm		1 device (30-day supply)	
☐ **EVENITY™** *(romosozumab)*	105 mg PFS	Inject 2 10 mg (2 syringes) SUBQ every month.	2 syringes (30-day supply)	
☐ **Other:**				
☐ **Other:**				

Start of Therapy Date:

Ship To: ☐ Patient ☐ MD Office 1st Order Only ☐ MD Office All Orders

As required by your state, Prescriberto check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:	
Office Contact:		Email:	
Address:	City:	State:	ZIP:
NPI #:		Tax ID:	
Prescriber Signature:		Date:	