OSTEOPOROSIS AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PraxisRx

PATIENT INFORMATION

Patient:_____ Caregiver: _____
DOB:_____ ☐ Male or ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Allergies:_____
Address:_____ City:_____ State:_____ Zip:_____
Primary Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell
Email:_____

CLINICAL INFORMATION

ICD-10 Code: ☐ M80.0 ☐ M80.8 ☐ M81.0
☐ M81.6 ☐ M81.8 ☐ M85.9
☐ M88.0 – M88.9 ☐ M89.9 ☐ M94.9

BMD/T-Score(s):_____ Location(s): _____ Date:_____

History of osteoporotic fracture? ☐ Yes ☐ No
If no, is patient at high risk? ☐ Yes ☐ No
If yes, date of fracture: _____ Location of fracture:_____

Please provide clinical rationale for prescribing this agent:

Prior therapies: _____ Reason for discontinuation: _____
Therapy: ☐ New ☐ Reauthorization Other: _____

PRESCRIPTION INFORMATION

☐ Boniva®	☐ 3mg/3mL PFS	☐ Inject the contents of 1 syringe (3mg) IV every 3 months. To be administered by a health care professional.	☐ One: 3mg/3mL PFS	**Refills:** _____
☐ Forteo® New Start? ☐ Y ☐ N Date therapy started: _____	☐ 600mcg/2.4mL Pen	☐ Inject 1 dose (20mcg) Sub-Q every day. Discard device 28 days after first use.	☐ 1 Pen (4-week supply) ☐ 3 Pens (12-week supply)	**Refills:** _____
☐ Prolia®	☐ 60mg/1mL PFS	☐ Inject the contents of 1 syringe (60mg) Sub-Q every 6 months.	☐ One: 60mg/1mL PFS	**Refills:** _____
☐ Reclast®	☐ 5mg/100mL Vial	☐ Infuse 5mg IV over no less than 15 minutes once annually. To be administered by a health care professional.	☐ One: 5mg/100mL Vial	0

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____
Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____
Prescriber: _____ NPI #: _____ Phone #: _____
Fax #: _____ Contact Name: _____
Office Address: _____ City: _____ State: _____ Zip: _____

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: _____ Date: _____
☐ DAW, Brand Medically Necessary