

Send updates to:  Fax: \_\_\_\_\_  Email: \_\_\_\_\_  Text: \_\_\_\_\_

### Physician Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice Name / Supervising MD:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

### Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

### Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

### Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	<input type="radio"/> Generalized (M81.0) <input type="radio"/> Postmenopausal (M81.0) <input type="radio"/> Drug Induced (M81.8) <input type="radio"/> Idiopathic (M81.8) <input type="radio"/> NEC <input type="radio"/> Pagets Disease (M89.9) <input type="radio"/> Other:					
Date of Diagnosis: / /	Lab in Box: <input type="radio"/> Y <input type="radio"/> N	First Dose: <input type="radio"/> Y <input type="radio"/> N				
TREATMENT ARRANGEMENTS:	Ship Meds: <input type="radio"/> Home <input type="radio"/> Doctor's Office	Start Date: / /	*Counseling and education provided by Meijer's Clinical Team			

### Prescription Information

Medication	Quantity/Dose	Sig	Refills
<input type="radio"/> <b>AREDIA®</b> <input type="radio"/> Vials	<input type="radio"/> Number of 30 mg vials: _____ <input type="radio"/> Number of 60 mg vials: _____ <input type="radio"/> Number of 90 mg vials: _____	<input type="radio"/> Infuse _____mg IV over _____ minutes once every _____	
<input type="radio"/> <b>BONIVA®</b> <input type="radio"/> Tablet <input type="radio"/> PFS (IV use)	<input type="radio"/> 1 carton (1x3mg/3ml)	<input type="radio"/> Infuse 3 mg IV every 3 months over a period of 15 to 30 seconds	
<input type="radio"/> <b>FORTEO®</b> <input type="radio"/> Prefilled Delivery Device	<input type="radio"/> 1 carton (1x600mcg/2.4ml)	<input type="radio"/> Inject 20 mcg SQ every day	
<input type="radio"/> <b>PROLIA®</b> <input type="radio"/> PFS	<input type="radio"/> 1 carton (1x60mg/ml)	<input type="radio"/> Inject 60mg SQ every six months	
<input type="radio"/> <b>RECLAST®</b> <input type="radio"/> Vial	<input type="radio"/> 1 carton (1x5mg/100ml)	<input type="radio"/> Infuse 5 mg IV over at least 15 minutes once every _____ year(s)	
<input type="radio"/> <b>TYMLOS™</b> <input type="radio"/> Pen	<input type="radio"/> 1 carton (1x3120mcg/1.56ml)	<input type="radio"/> Inject 80 mcg SQ once daily	
<input type="radio"/> <b>ZOMETA®</b> <input type="radio"/> Vial	<input type="radio"/> 1 carton (1x4mg/5ml)	<input type="radio"/> Infuse 4 mg IV over no less than 15 minutes once every _____	
<input type="radio"/> Other:			

### Injection Training

<input type="radio"/> Patient received injection training	<input type="radio"/> Prescriber's office to provide injection training	<input type="radio"/> Meijer to coordinate injection training	<input type="radio"/> Patient to receive injection training at Meijer
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By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature:	Date
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Physician Signature:	Date
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Substitution Permitted

Dispense as Written