

Prescriber Information							
Prescriber Name:			MD	DO	NP	PA	NPI:
Office Contact:				Practice Name / Collaborating MD:			
Address:			City:		State:		Zip:
Phone:		Fax:					

Patient Information • PLEASE SEND COPY OF INSURANCE CARD								
Patients Name:		Last 4 Digits of SS#:		DOB: / /	Sex: M F	Weight:	Height:	Diabetic? Y N
Address:			City:		State:		Zip:	
Home Phone:		Work/Cell:		HIPAA Contact:		Emergency #:		
Interpreter Needed? Y N	Allergies: Y N If Yes, list allergies:							

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

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:		Osteoporosis with current pathological fracture (M80.____)		Osteoporosis without current pathological fracture (M81.____)		Age-related osteoporosis (M80.0____)	
Paget's Disease (M88)		Other:					
T-Score:		Previous Therapies:					
History of Fractures: Y N	Fracture Code:	Site Fracture Code:	Date of Diagnosis: / /	First Dose: Y N			

Prescription Information			
Medication	Quantity/Dose	Sig	Refills
<b>BONIVA®</b>	3 mg/ml PFS (for IV use)	Infuse 3 mg IV every 3 months over a period of 15 to 30 seconds	
<b>EVENITY™</b>	1 carton (2x105mg/1.17ml PFS)	Inject two syringes (210mg) SQ once monthly	
<b>FORTEO®</b> *Needles required	1 carton (1x600mcg/2.4ml Pen) 3 cartons (3x600mcg/2.4ml Pen) Pen needles - ____ box(es) of 30	Inject 20 mcg SQ every day Use one needle daily with injection	
<b>PROLIA®</b>	60mg/ml PFS	Inject 60mg SQ every six months	
<b>RECLAST®</b>	5mg/100ml vial	Infuse 5 mg IV over at least 15 minutes once every ____ year(s)	
<b>TERIPARATIDE</b> *Needles required	1 carton (1x620mcg/2.48ml Pen) 3 cartons (3x620mcg/2.48ml Pen) Pen needles - ____ box(es) of 30	Inject 20mcg SQ every day Use one needle daily with injection	
<b>Other</b>			

Injection Training		
Patient received injection training	Prescriber's office to provide injection training	Meijer to coordinate injection training

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.

Prescriber Signature	Date	Prescriber Signature	Date
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.