

Patient Information

Last Name		First Name		Home Phone		Work/Mobile Phone	
Home Address				City		State ZIP	
Shipping Address (if different from above)				City		State ZIP	
Social Security Number	Gender (M/F)	Weight	Date of Birth	Allergies			
Emergency Contact		Phone		Primary Caregiver		Phone	

Healthcare Provider Information:

Practice/Facility Name		Physician Name		Phone/Fax	
Address			City		State ZIP
Physician UPIN#	Physician DEA#	Physician State License #		Physician NPI #	
Nurse/Key Contact		Phone or Pager Number		Email	

Insurance Information: **PLEASE FAX A COPY OF INSURANCE CARD (FRONT AND BACK)**

Diagnosis: ☐ 733.00 Osteoporosis, Unspecified ☐ 733.01 Senile Osteoporosis ☐ 733.02 Idiopathic Osteoporosis ☐ 733.03 Disuse Osteoporosis ☐ 733.09 Other Osteoporosis ☐ V58.65 Long-term (current) use of Steroids ☐ Other: _____		Prior (FAILED) Therapy: <table border="1"> <thead> <tr> <th>Therapy</th> <th>Date(s)</th> </tr> </thead> <tbody> <tr><td>☐ Fosamax</td><td></td></tr> <tr><td>☐ Actonel</td><td></td></tr> <tr><td>☐ Forteo</td><td></td></tr> <tr><td>☐ Prolia</td><td></td></tr> <tr><td>☐ Reclast</td><td></td></tr> <tr><td>☐ Boniva</td><td></td></tr> <tr><td>☐ Other:</td><td></td></tr> </tbody> </table>	Therapy	Date(s)	☐ Fosamax		☐ Actonel		☐ Forteo		☐ Prolia		☐ Reclast		☐ Boniva		☐ Other:	
Therapy	Date(s)																	
☐ Fosamax																		
☐ Actonel																		
☐ Forteo																		
☐ Prolia																		
☐ Reclast																		
☐ Boniva																		
☐ Other:																		
Date of Diagnosis: _____ BMD/T-Score: _____ Is patient new to therapy? ☐ Yes ☐ No History of osteoporotic fracture? ☐ Yes ☐ No If no, is patient at high risk? ☐ Yes ☐ No If yes, date of fracture: _____ Location of fracture: _____																		

Delivery Information

Today's Date	Delivery Date	Deliver to: ☐ Home ☐ Physician	Amber Pharmacy to initiate arrangement of injection training to take place at patient's home ☐ Yes ☐ No	Special Instructions
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Medication	Dose/Strength	Sig	Qty.	Refills
☐ Boniva® ☐ DAW	☐ 3 mg/3 mL PFS	☐ Inject contents of 1 syringe (3 mg) intravenously every 3 months. To be administered by a healthcare professional	One: 3 mg/3 mL PFS	
☐ Forteo®	☐ 600 mcg/2.4 mL Pen	☐ Inject 1 dose (20 mcg) SQ once daily. Discard device 28 days after first use.	☐ 1 pen (4-week supply) ☐ 3 pens (12-week supply)	
☐ Pen Needles	☐ 31 G x 3/16" mini ☐ 31 G x 5/16" short	☐ Use with Forteo® pen once daily as directed	#100 Pen Needles	
☐ Prolia®	☐ 60 mg/1 mL PFS	☐ Inject the contents of 1 syringe (60 mg) SQ every 6 months.	1 Prefilled Syringe	
☐ Reclast® ☐ DAW	☐ 5 mg/100 mL vial	☐ Infuse 5 mg intravenously over no less than 15 minutes once annually.	One: 5 mg/100 mL vial	0
☐ Other:				

When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature: _____ **Date** ____/____/____

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.