Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

Osteoporosis Enrollment Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821

Single Point of Contact: (724) 515-7053

Start Date:____________ **Ship to:** __Patient __Office ____________Other

1. Patient Information

Patient Name: ____ Male / Female DOB:____________

Address: ____

Soc. Sec. # _________________ Phone #:__________________ Alt Phone #:__________________

Caregiver:________________________________ Allergies: ______________________________

Comorbidities: ____________________________ Height:________________ Weight: ____________

2. Clinical Information *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:____________________ Test Results: _______________________________

Prior Therapies: ____

Affected Area (s): ____

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Forteo®	__ 600mcg / 2.4mL Pen *(1 pen = 28 doses)*	__ inject 20mcg Sub-Q daily __	__ 1 Pen __	
	Prolia®	__ 60 mg / mL PFS	__ inject 60mg Sub-Q once every 6 months	__ 1 PFS __	
	Tymlos®	__ 2mg / mL Pen *(1 pen = 30 doses)*	__ inject 80mcg Sub-Q daily __	__ 1 Pen __	

4. Prescriber and Shipping Information

Prescriber (print): ________________________________ Office Contact: ______________________

Prefered Method of Contact: __phone __fax __email Contact email:______________________

Office Address: ____

Phone: ______________________________ Fax: ______________________________

NPI: ______________________________ DEA:______________________________

Prescriber's Signature: ____ Date: ____________

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information **Please fax a copy of insurance card front and back. Enlarge if possible.**

IMPORTANT NOTICE:this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately.
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