Optum

Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

Osteoporosis Enrollment Form

Specialty Pharmacy Enrollment Form ✂ Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona or Virginia**

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____

Address _____

Address 2 _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ ICD-10 _____ Description _____

Disease State Description:

☐ Postmenopausal osteoporosis with high fracture risk (female)

☐ Postmenopausal osteoporosis prophylaxis

☐ Hypogonadal osteoporosis with high fracture risk (male)

☐ Glucocorticoid-induced osteoporosis treatment/prophylaxis

☐ Paget's disease

☐ Other: _____

Date of Diagnosis _____

Test Results: **WNL:**

☐ Serum calcium _____ ☐ Yes ☐ No

☐ SCr/CrCl _____ ☐ Yes ☐ No

☐ BMD _____ ☐ Yes ☐ No

☐ T score _____ ☐ Yes ☐ No

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2

Allergies _____

Fracture History _____

Prior Failed Therapies:

☐ Actonel® (risedronate) ☐ Boniva® (ibandronate)

☐ Fosamax® (alendronate) ☐ Prolia® (denosumab)

☐ Reclast® (Zoledronic Acid Injection)

Concomitant Medications _____

Additional Comments _____

Treatment Start Date _____ Treatment End Date _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Evenity® (romosozumab-aqqg)				
☐ Forteo® (teriparatide, recombinant)				
☐ Prolia® (denosumab)				
☐ Reclast® (zoledronic acid)				
☐ Tymlos® (abaloparatide)				

Ship to: ☐ Office ☐ Other _____ Date _____ Date Needed _____

* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Dispense as Written

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

Substitution permitted

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.