ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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OSTEOPOROSIS ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last updated 07.15.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com
Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____ Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)
Primary Insurance: Name of Insurer:_____ ID#:_____ BIN#: _____ PCN#:_____ Group#:_____ Phone:_____
Secondary Insurance: Name of Insurer:_____ ID#:_____ BIN#: _____ PCN#:_____ Group#:_____ Phone:_____

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Injection Training & Education Needs: □Patient has received injection training □Physician's office to provide injection training

Diagnostic Information: Diagnosis (Please provide ICD-10-CM codes) □M81.0 Osteoporosis, postmenopausal □M81.8 Osteoporosis, drug induced
□M84.40XA Osteoporosis, unspecified fracture □M80.08XA Osteoporosis, fracture of the vertebrae □Other_____
Date of Diagnosis:_____

Clinical Information:
Is patient new to therapy □Yes □No If no, start date of therapy:_____
History of osteoporotic fracture □Yes □No If yes, date of fracture:_____ Location of fracture:_____
BMD/T-Score:_____ Date:_____
Prior Failed Therapies:_____

Drug Name	Strength	Directions	Quantity	Refills
□Forteo®	□600 mcg/2.4mL Pen (20 mcg multi-dose pen containing 28 daily doses)	Inject 20mcg SQ Daily	□1 pen (4 week supply) □3 pens (12 week supply) □Other:_____	
□*Pen Needles*	□*5mm-31gauge* □*8mm-31gauge* □*Other:*_____	*Use with Forteo® pen once daily*	□*4 week supply* □*12 week supply* □*Other:*_____	
□Prolia®	□60mg/mL Prefilled Syringe	Inject 60mg SQ Q 6 months	□6 month supply □Other:_____	
□Tymlos™	□3120 mcg/1.56 mL Pen (80 mcg multi-dose pen containing 30 daily doses)	Inject 80mcg SQ Daily	□1 pen (1 month supply) □3 pens (3 month supply) □Other:_____	
□*Pen Needles*	□*5mm-31gauge* □*8mm-31gauge* □*Other:*_____	*Use with Tymlos™ pen once daily*	□*1 pen (1 month supply)* □*3 pens (3 month supply)* □*Other:*_____	
□Other			SQ = subcutaneously	

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation):_____ Date:_____ □Please select if you would like the patient enrolled in a Manufacturer's Assistance Program