



www.acropharmacy.com
 Sharon Hill, PA
 Phone: 800.906.7798
 Fax: 877.381.3806
 NCPDP: 3982902
 NPI: 1639103823

Memphis, TN
 Phone: 800.906.7798
 Fax: 844.612.9057
 NCPDP: 4447783
 NPI: 1518349562

OSTEOPOROSIS ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last updated 07.15.2018



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: _____	Provider Office: (Please provide as much information as possible)	Prescriber's Name: _____ Group/Hospital: _____
	Address: _____		Specialty: _____ License#: _____ Tax ID#: _____
	City, State, Zip: _____		Address: _____
	Preferred Phone: _____ Alt. Phone: _____		NPI: _____ DEA: _____
	Last four digits of SS#: _____ Date of Birth: _____		City, State, Zip: _____
	Gender: _____ Allergies: _____ Height: _____ Weight: _____		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
<input type="checkbox"/> Forteo®	<input type="checkbox"/> 600 mcg/2.4mL Pen (20 mcg multi-dose pen containing 28 daily doses)	Inject 20mcg SQ Daily	<input type="checkbox"/> 1 pen (4 week supply) <input type="checkbox"/> 3 pens (12 week supply) <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Pen Needles	<input type="checkbox"/> 5mm-31gauge <input type="checkbox"/> 8mm-31gauge <input type="checkbox"/> Other: _____	Use with Forteo® pen once daily	<input type="checkbox"/> 4 week supply <input type="checkbox"/> 12 week supply <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Prolia®	<input type="checkbox"/> 60mg/mL Prefilled Syringe	Inject 60mg SQ Q 6 months	<input type="checkbox"/> 6 month supply <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Tymlos™	<input type="checkbox"/> 3120 mcg/1.56 mL Pen (80 mcg multi-dose pen containing 30 daily doses)	Inject 80mcg SQ Daily	<input type="checkbox"/> 1 pen (1 month supply) <input type="checkbox"/> 3 pens (3 month supply) <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Pen Needles	<input type="checkbox"/> 5mm-31gauge <input type="checkbox"/> 8mm-31gauge <input type="checkbox"/> Other: _____	Use with Tymlos™ pen once daily	<input type="checkbox"/> 1 pen (1 month supply) <input type="checkbox"/> 3 pens (3 month supply) <input type="checkbox"/> Other: _____	
<input type="checkbox"/> 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

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