

FAST TRACK OSTEOPOROSIS ORDER FORM

PATIENT INFORMATION			
Patient Name: _____	DOB: _____	Phone: _____	<input type="checkbox"/> Demographics attached
INSURANCE INFORMATION: PLEASE ATTACH A COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK			
MEDICAL INFORMATION			
Diagnosis: <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Glucocorticoid-induced osteoporosis <input type="checkbox"/> Paget's disease of bone			
<input type="checkbox"/> Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached			
<input type="checkbox"/> DEXA Scan, within 2 years (-2.5 T score or more severe) ** if no -2.5 T score, documented FRAX ≥ 20% for major osteoporotic fracture or ≥ 3% for hip fracture, documented fragility fracture, or any other notable risk factors			
<input type="checkbox"/> Serum calcium WNL, within 2 months			
<input type="checkbox"/> eGFR > 30 mL/min, within 2 months			
<input type="checkbox"/> Serum 25-hydroxy vitamin D ≥ 30 ng/mL			
Tried & Failed Medications			
<input type="checkbox"/> Fosamax/ alendronate <input type="checkbox"/> Boniva/ ibandronate <input type="checkbox"/> Actonel/ risedronate <input type="checkbox"/> Reclast/ zoledronic acid <input type="checkbox"/> Prolia/ denosumab <input type="checkbox"/> Forteo/ teriparatide <input type="checkbox"/> Tymlos/ abaloparatide <input type="checkbox"/> Evenity/ romosozumab <input type="checkbox"/> Evista/ raloxifene	<i>Duration:</i> _____ _____ _____ _____ _____ _____ _____ _____	<i>Reason for discontinuing:</i> _____ _____ _____ _____ _____ _____ _____ _____	
ZOLEDRONIC ACID			
* Patient is currently taking calcium/vitamin D supplementation <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Other _____			
<input type="checkbox"/> Zoledronic Acid 5 mg IV once yearly dx: osteoporosis			
<input type="checkbox"/> Zoledronic Acid 5 mg IV every other year dx: osteopenia			
<input type="checkbox"/> Zoledronic Acid 5 mg IV x1 dx: Paget's disease of the bone			
PROLIA			
* Patient is currently taking calcium/vitamin D supplementation <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Other _____			
<input type="checkbox"/> Prolia 60 mg subcutaneous injection every 6 months			
EVENITY			
* Patient is currently taking calcium/vitamin D supplementation <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Other _____			
** No history of MI or stroke within the past 12 months			
<input type="checkbox"/> Evenity 210 mg subcutaneous injection once monthly (max 12 months)			
PROVIDER INFORMATION			
<i>By signing this form and utilizing our services, you are authorizing Community Care Rheumatology and its staff to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.</i>			
Provider Signature: _____			Date: _____
Provider Name: _____			
Phone: _____		Fax: _____	
Contact Person: _____			

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