Elite Specialty Pharmacy
Your Choice Above The Rest

Osteoporosis Enrollment Form

Fax Referrals To: (877) 577-6447

Nzone-Elite Specialty Pharmacy
10210 101st Ave
Ozone Park, NY 11416
Toll Free: (877) 577-1447

PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ M ☐ F ☐ SS#: _____
Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION:

Name: _____
Group/Institution: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY:

☐ DEXA: _____

☐ M81.0 Age related osteoporosis without current pathological fracture
☐ M80.0 Age-related osteoporosis with current pathological fracture

Does the patient have a history of osteoporotic fracture? ☐ Yes ☐ No
Has the patient failed or is unable to tolerate bisphosphonate therapy? ☐ Yes ☐ No
If yes, please explain: _____
Does the patient have >1 risk factor for fracture? ☐ Yes ☐ No
If yes, please explain: _____
Will the patient be adequately supplemented with Calcium and Vitamin D? ☐ Yes ☐ No

Prior Failed Treatments:	Indicat Length of Treatment and Results:
☐ Fosamax® (alendronate)	_____
☐ Actonel® (risedronate)	_____
☐ Boniva® (ibandronate)	_____
☐ Prolia® (denosumab)	_____
☐ Reclast® (Zoledronic Acid)	_____

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
☐ Boniva®	3mg/3mL prefilled syringe	Inject the contents of 1 syringe (3 mg) intravenously every 3 months.	☐ 1 prefilled syringe	
☐ Forteo®	600ug/2.4ml	Inject 20ug (0.08ml) subcutaneous once daily	☐ 1 device (28-day supply) ☐ 3 devices (84-day supply)	
☐ 31G Pen Needles	☐ 5mm ☐ 6mm ☐ 8mm	Use with Forteo Delivery Device as directed	☐ 28-day supply ☐ 84-day supply	
☐ Prolia®	60mg	Inject 60mg subcutaneous every 6 months		
☐ Reclast®	5mg	Infuse 5mg IV once a year	☐ 1 vial	
☐ Tymlos™	3120 mcg/1.56ml	Inject 80 mcg (0.04 mL) subcutaneously once daily	☐ 1 device (30-day supply) ☐ 3 devices (90-day supply)	
☐ 31G Pen Needles	☐ 8mm	Use with Tymlos delivery device as directed	☐ 30-day supply ☐ 90-day supply	
☐ Other				

INJECTION TRAINING: ☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRODUCT DELIVERY: ☐ Patient's home ☐ Physician's Office ☐ Pharmacy to coordinate

INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIBER SIGNATURE:

Your signature authorizes Nzone Pharmacy, LLC and its representatives to act on your behalf to obtain prior authorization for the prescribed medications. We will also purse available copay and financial assistance on behalf of your patients.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.