Absolute Wellness
PHARMACY

OSTEOPOROSIS ENROLLMENT FORM

Fax: 818-912-6989
Call: 818-912-6800

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt Phone: _____
Email: _____
DOB: _____ ☐ M ☐ F Last 4 of SSN: _____

2 PRESCRIBER INFORMATION:

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

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: _____ Drug Allergies: ☐ NKDA ☐ _____

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: _____

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: _____

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: _____

PRESCRIPTION INFORMATION:

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Forteo®**	☐ 600mcg/2.4ml Pen	☐ Inject 20mcg SC once daily		
☐ **Pen Needles**	☐ 31 Gauge ☐ 5mm			
☐ **Prolia®**	☐ 60mg/ml Prefilled Syringe	☐ Inject 60mg SC every 6 months		
☐ **Tymlos™**	☐ 3120mcg/1.56ml Pen	☐ Inject 80mcg SC once daily into the periumbilical region of the abdomen		
☐ **Pen Needles**	☐ 31 Gauge ☐ 5mm			
☐	☐	☐		

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

X PHYSICIAN SIGNATURE REQUIRED

Substitution Permitted | Date | X _____ Dispense as Written | Date