benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

OSTEOPOROSIS REFERRAL FORM

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID _____

Medicaid ID # _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____ Secondary Insurance (if applicable) _____

Insurance Phone _____ Insurance Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

CLINICAL INFORMATION

Prior Failed Medication(s): Length of Treatment: Reason for Discontinuing:

_____ _____/_____/_____-_____/_____/_____ _____

_____ _____/_____/_____-_____/_____/_____ _____

_____ _____/_____/_____-_____/_____/_____ _____

Diagnosis Date: _____/_____/_____

☐ M88 Paget's Disease
☐ M81 Unspecified Osteoporosis
☐ M81.0 Postmenopausal/Senile Osteoporosis
☐ M81.8 Drug-induced Osteoporosis
☐ M84.4 Pathological Fracture
☐ Other: _____

Lowest Dexa T-score: _____ Site: _____ Date: _____/_____/_____

Fracture Site(s): _____ Date: _____/_____/_____

Allergies:

DRUG NAME	PRESCRIPTION ORDERS *(PLEASE CHECK ONE OR MORE)*	QUANTITY	REFILLS
☐ Boniva® ☐ Pre-filled Syringe	☐ Inject 3mg IV over 15-30 seconds every 3 months	3mg/3ml (1 syringe)	
☐ Evenity® ☐ Pre-filled Syringe	☐ Inject 210mg subcutaneously once monthly	☐ 2 pen ☐ 6 pens	
☐ Forteo® ☐ Pen and Supplies	☐ Inject 20mcg subcutaneously daily	☐ 1 pen ☐ 3 pens	
☐ Prolia® ☐ Pre-filled Syringe	☐ Inject 60mg subcutaneously once every 6 months	60mg/ml (1 syringe)	
☐ Reclast® ☐ Vial	☐ Infuse 5mg IV, over no less than 15 minutes, every year ☐ Infuse 5mg IV, over no less than 15 minutes, every two years	5mg/100ml (1 vial)	
☐ Tymlos® ☐ Pen and Supplies	☐ Inject 80mcg subcutaneously daily	☐ 1 pen ☐ 3 pens	
Injection Training: ☐ Patient has received injection training ☐ Physician's office to provide injection training			

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not