Osteoporosis Enrollment Form Medications A-S

(Evenity, Forteo, Prolia, Reclast)



Fax Referral To: 1-800-323-2445 Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 1-800-237-2767

		Six Simple Steps to Submitting a Referral	
PATIENT IN	FORMATION (Cor	nplete or include demographic sheet)	
Address:		City, State, ZIP Code:	
Gender: 🗌 Male	🗌 Female		
Preferred Contac	t Methods: 🗌 Phone	(to primary # provided below) 🗌 Text (to cell # provided below) 🗌 Emai	l (to email provided below)
		to contact via text or email, Specialty Pharmacy will attempt to contact by	
Primary Phone: _		Alternate Phone:	
		Name (Last, First):	
Relationship to r	ninor:		
_		Last Four of SSN: Primary Lar	iguage:
2 PRESCRIBE	R INFORMATION	1	
Prescriber's Nam	ne:	State License #:	
		Group or Hospital:	
Address:		City, State, ZIP Code: xContact Person:Contact	
Phone:	Fa	x Contact Person: Contact	xt's Phone:
3 INSURANCI	E INFORMATION	Please fax copy of prescription and insurance cards with this for	m, if available (front and back)
_	AND CLINICAL		•
		p to: 🗌 Patient 🗌 Office 🗌 Other:	-
Diagnosis (ICD-1		ith ourrent nothological fracture	
		ith current pathological fracture ithout current pathological fracture	
		tion	
Patient Clinical I			
		lb/kg Height:lb/kg Height:in/	/cm
	ION INFORMATI		
5 PRESCRIPT MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
MEDICATION	STRENGTH		
Evenity	105 mg/1.17 mL	Administer two consecutive subcutaneous injections (105 mg	Quantity: 2 syringes
	100 mg/	each) for a total dose of 210 mg once monthly for 12 doses	Refills: 11
			Quantity:
	600 mcg/2.4 mL		1 device (28-day supply)
Forteo	(250mcg/mL)	Inject 20 mcg (0.08 mL) subcutaneously once daily.	3 devices (84-day
	Delivery Device		supply)
	-		Refills:
	31G Pen Needles:		Quantity:
	🗌 5 mm	Lies with Fautos delivery device as divested	28-day supply
Forteo	🗌 6 mm	Use with Forteo delivery device as directed.	84-day supply
	🗌 8 mm		Refills:
			Quantity:
Prolia	60 mg	Inject 60 mg subcutaneously every 6 months.	Refills:
		Infuse 5 mg IV once a year over no less than 15 minutes.	
Reclast	5 mg	Infuse 5 mg IV once every 2 years over no less than 15	Quantity: 1 vial
		minutes.	Refills:
Patient is interested in	n patient support programs		and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution /		May Substitute / Product Selection Permitted /	
DAW / May Not Substitute		Substitution Permissible	
Prescriber's Signature: Date:		Prescriber's Signature: Date:	
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"			ers, please submit electronic prescription

The information provided above is true and accurate to the best ofmy knowledge, with supporting documentation in the patient's medical record. By signing above, 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.

Osteoporosis Enrollment Form

Medications T-Z

(Teriparatide . Tymlos)

Please Complete Patient and Prescriber Information				
Patient Name:	Patient DOB:			
Prescriber Name:	Prescriber Phone:			

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
Teriparatide Injection* (*FDA approved treatment alternative to Forteo-Not automatically substituted for Forteo)	620 mcg/2.48 mL (250 mcg/mL) Delivery Device	Inject 20 mcg (0.08 mL) subcutaneously once daily.	Quantity: 1 device (28-day supply) 3 devices (84-day supply) Refills:
Teriparatide	31G Pen Needles: 5 mm 6 mm 8 mm	Use with Teriparatide Delivery Device as directed.	Quantity: 4-week supply 12-week supply Refills:
Tymlos	3120 mcg/1.56 mL	Inject 80 mcg (0.04 mL) subcutaneously once daily.	Quantity: 1 device (30-day supply) 3 devices (90-day supply) Refills:
Tymlos	31G Pen Needles: 5 mm 6 mm 8 mm	Use with Tymlos delivery device as directed.	Quantity: 30-day supply 90-day supply Refills:

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute		May Substitute / Product Selection Permitted / Substitution Permissible	
Prescriber's Signature:	Date:	Prescriber's Signature:	Date:
CA, MA, NC & PR: Interchange is mandated unless Prescriber	writes the words " No Substitution "	ATTN: New York and Iowa providers	s, please submit electronic prescription

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 above, 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.

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