HOME PARENTERAL SERVICES

OSTEOPOROSIS

PHONE: **1-800-637-9201**
FAX: **1-417-269-0692**

Start Date _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ /____ / ____ ☐ Female ☐ Male SSN: ____ -____ - ____

Address: _____ _____ City: _____ ___ State: _____ Zip: _____ _____

Phone: (____) - ____ - _____ Alternate Phone: (____) - ____ - _____ email: _____

Preferred method of contact: ☐ Phone ☐ Email ☐ Text ☐ Other: _____ Height: _____ in Weight: _____ lb

Allergies: Medications:

ICD-10 Code ☐

Please attach additional pages if necessary, including front and back of insurance card

PRESCRIBER INFORMATION

Prescriber Name: _____

Office Phone: (____) - ____ - _____ Fax: (____) - ____ - _____ Contact: _____ _____

Clinic/Hospital Affiliation: _____

Address: _____ City: _____ State: _____ Zip: _____

License #: _____ NPI #: _____ Medicaid Provider #: _____

PRESCRIPTION INFORMATION

PRODUCT/STRENGTH	DOSE	SIG	REQUESTED DELIVERY DATE	REFILLS
❑ BONIVA 3MG/3ML	3MG	INFUSE 3 MG INTRAVENOUS OVER 15 TO 30 SECONDS EVERY 3 MONTHS		
❑ FORTEO 600 MCG 2.4 ML	20 MCG	INJECT 20 MCG SUBCUTANEOUS DAILY		
❑ PROLIA 60 MG/ML	60 MG	INJECT 60 MG SUBCUTANEOUS Q 6 MONTHS		
❑ ZOLEDRONIC ACID 5MG/100 ML	5MG	INFUSE 5MG INTRAVENOUS OVER 15 MINUTES YEARLY (TREATMENT OF OSTEOPOROSIS)		
❑ ZOLEDRONIC ACID 5MG/100 ML	5MG	INFUSE 5 MG INTRAVENOUS OVER 15 MINUTES Q 2 YEARS (PREVENTION OF OSTEOPOROSIS)		
❑ TYMLOS 2000MCG/ ML	80MCG	INJECT 80 MCG SUBCUTANEOUS DAILY		

Supplies for FORTEO and TYMLOS injections 31 G 8mm Pen Needles Quantity: 30 Refill: 12

By signing below, I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ _____ Date: ____ /____ / ____

May Substitute Dispense as Written

INJECTION TRAINING PROVIDED BY

☐ Physician/ Clinic ☐ HPS ☐ Not Needed

PATIENT INJECTION SETTING

☐ Physician/ Clinic ☐ HPS ☐ Patient Home (if approved)

SHIPPING INFORMATION

Ship to: ☐ Physician/Clinic ☐ Patient Date Shipment Needed By: ____ /____ / ____