

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
<input type="checkbox"/> BONIVA 3MG/3ML	3MG	INFUSE 3 MG INTRAVENOUS OVER 15 TO 30 SECONDS EVERY 3 MONTHS		
<input type="checkbox"/> FORTEO 600 MCG 2.4 ML	20 MCG	INJECT 20 MCG SUBCUTANEOUS DAILY		
<input type="checkbox"/> PROLIA 60 MG/ML	60 MG	INJECT 60 MG SUBCUTANEOUS Q 6 MONTHS		
<input type="checkbox"/> ZOLEDRONIC ACID 5MG/100 ML	5MG	INFUSE 5MG INTRAVENOUS OVER 15 MINUTES YEARLY (TREATMENT OF OSTEOPOROSIS)		
<input type="checkbox"/> ZOLEDRONIC ACID 5MG/100 ML	5MG	INFUSE 5 MG INTRAVENOUS OVER 15 MINUTES Q 2 YEARS (PREVENTION OF OSTEOPOROSIS)		
<input type="checkbox"/> 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 CoxHealth at Home 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: ____/____/____

INJECTION TRAINING PROVIDED BY

Physician/ Clinic CoxHealth at Home Not Needed

PATIENT INJECTION SETTING

Physician/ Clinic CoxHealth at Home Patient Home (if approved)

SHIPPING INFORMATION

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