infusioncare
OF COMMUNITY CARE PHYSICIANS

FAST TRACK OSTEOPOROSIS ORDER FORM

PATIENT INFORMATION			
Patient Name:	DOB:	Phone:	◯ Demographics attached
INSURANCE INFORMATION: PLEASE ATTACH A COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK			

MEDICAL INFORMATION			
Diagnosis:	◯ Osteoporosis	◯ Glucocorticoid-induced osteoporosis	◯ Paget's disease of bone

◯ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached
◯ DEXA Scan, within 2 years (-2.5 T score or more severe) ** if no - 2.5 T score, documented FR RAAX ≥ 20% for major osteoporotic fracture or ≥ 3% for hip fracture, documented fragility fracture, or any other notableble r risk factors

◯ Serum calcium WNL, within 30 days
◯ eGFR > 30 mL/min, within 30 days
◯ Serum 25-hydroxy vitamin D ≥ 30 ng//mL

Tried & Failed Medications

	Duration:	*Reason for discontinuing:*
◯ Fosamax/ alendronate	_____	_____
◯ Boniva/ ibandronate	_____	_____
◯ Actonel/ risedronate	_____	_____
◯ Reclast/ zoledronic acid	_____	_____
◯ Prolia/ denosumab	_____	_____
◯ Forteo/ teriparatide	_____	_____
◯ Tymlos/ abaloparatide	_____	_____
◯ Evenity/ romosozumab	_____	_____
◯ Evista/ raloxifene	_____	_____

ZOLEDRONIC ACID

* Patient is currently taking calcium/vitamin D supplementation ◯ YES ◯ NO ◯ Other _____
◯ Zoledronic Acid 5 mg IV once yearly dx: osteoporosis
◯ Zoledronic Acid 5 mg IV every other year dx: osteopenia
◯ Zoledronic Acid 5 mg IV x1 dx: Paget's disease of the bone

PROLIA

* Patient is currently taking calcium/vitamin D supplementation ◯ YES ◯ NO ◯ Other _____
◯ Prolia 60 mg subcutaneous injection every 6 months

EVENITY

* Patient is currently taking calcium/vitamin D supplementation ◯ YES ◯ NO ◯ Other _____
** No history of MI or stroke within the past 12 months
◯ Evenity 210 mg subcutaneous injection once monthly (max 12 months)

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Community Care Rheumatology and its staff to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Signature:_____ Date: _____
Provider Name:_____
Phone: _____ Fax: _____ Contact Person: _____

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