



FAX 1-844-504-3278  
 PHONE 1-877-327-8881  
 www.FASTACCESSRX.com

**OSTEOPOROSIS FORM**

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Male:  Female:   
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Tel: \_\_\_\_\_ Alt Tel: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_  
 NKDA:  Allergy: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Pharmacy Insurance \_\_\_\_\_  
 Member Name: \_\_\_\_\_  
 Member ID: \_\_\_\_\_  
 Rx Group #: \_\_\_\_\_  
 BIN# \_\_\_\_\_ PCN# \_\_\_\_\_  
 Customer Service #: \_\_\_\_\_  
***Please attach a copy of the front and back of the patient's insurance card, if available.\*\*\*\*\****

**DIAGNOSIS AND CLINICAL INFORMATION:**

ICD10 code:  M81.0 ICD10 Code: \_\_\_\_\_ T-score: \_\_\_\_\_  
 Prior meds failed: \_\_\_\_\_  
 Forteo® Home Health Training Required

**PRESCRIBER INFORMATION:**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 NPI#: \_\_\_\_\_ DEA #: \_\_\_\_\_ UPIN #: \_\_\_\_\_

By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature Below: *(Physician attests this is his/her legal signature. NO STAMPS)*

\_\_\_\_\_  
*Substitution Allowed*

\_\_\_\_\_  
*Dispense as Written*

**PRESCRIPTION:**

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Forteo®	600mcg/2.4ml	Inject 20mcg subq daily	1 month	_____
<input type="checkbox"/> Prolia®	60mg	Inject 60mg subq every 6 months	1 month	_____
<input type="checkbox"/> Reclast®	5mg/100ml	Infuse 5mg once yearly	1 vial	_____
<input type="checkbox"/> Other	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____