

PATIENT INFORMATION **MEDICAL INFORMATION** (Please attach or complete all known medical history)

Patient Name _____ Male Female
 Date of Birth _____ English Spanish Other _____
 Address _____ Apt # _____
 City _____ State _____ Zip _____
 Phone # - Primary _____ Secondary _____
 Email Address _____
 Social Security # _____
 Allergies _____ NKA
 Weight _____ kg lb Height _____ in cm
 Emergency Contact Name _____
 Emergency Contact Phone _____
 Please attach copy of insurance information or copy of insurance cards (both sides).

Diagnosis
 731.0 Paget's Disease 733.09 Osteoporosis Other, Drug-induced
 733.00 Osteoporosis Unspecified 733.13 Pathological Fracture of Vertebrae
 733.01 Postmenopausal Osteoporosis 733.14 Pathological Fracture of Neck of Femur
 733.02 Idiopathic Osteoporosis Other (include code) _____
 Date of Initial Diagnosis _____ Diagnosis Description _____
 Lowest DEXA T-score _____ T-score Date _____ Site _____
 Previous Fracture(s) Yes No
 If no, is patient high risk? Yes No
 If yes, date/site of fracture(s) _____

SHIPPING INFORMATION
 New Refill Date Medication Needed: _____
 Injection Training Needed
 Ship to: Patient's Home Physician's Office
 Other _____

Prior Failed Medication(s):	Length of Treatment:	Reason for Discontinuing:

PHYSICIAN INFORMATION

Physician Name _____
 Physician NPI _____ License # _____
 Office Contact Name _____
 Address _____ Ste # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 By signing this form, I authorize Maxor Specialty to act as my agent for Prior Authorizations & Prescription Reimbursement for the above listed patient.
 Physician Signature _____
 Date _____
 Dispense as written Product substitution permitted
****For Ohio patients, please only choose one (1) prescription per form.****

PRESCRIPTION INFORMATION

Medication	Strength/Size	Directions	Quantity	Refills
<input type="checkbox"/> Boniva®	3 mg/3 ml (1 PFS)	Inject 3 mg IV over 15-30 seconds every 3 months		
<input type="checkbox"/> Forteo®	600 mcg/2.4 ml 1 Pen and Supplies	Inject 20 mcg/0.8 ml SQ once daily		
<input type="checkbox"/> Prolia®	60 mg/ml (1 PFS)	Inject 60 mg SQ once every 6 months		
<input type="checkbox"/> Reclast®	5 mg/100 ml vial	<input type="checkbox"/> Infuse 5 mg IV over no less than 15 minutes, every year <input type="checkbox"/> Infuse 5 mg IV over no less than 15 minutes, every two years		

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