DELTADRUGS

Osteoporosis

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Patient SSN#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ 2nd Phone #: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Weight (lbs): _____ Height (in.): _____ Allergies: _____

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ Phone #: _____ ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Diagnosis

- ❑ M80.0 Age-related osteoporosis w/fracture
- ❑ M80.8 Other osteoporosis w/fracture
- ❑ M81.0 Age-related osteoporosis w/o fracture
- ❑ M81.6 Localized Osteoporosis
- ❑ M81.8 Other Osteoporosis w/o fracture
- ❑ M85.9 Bone density and structure disorders
- ❑ M88.0 Paget's Disease
- ❑ M89.9 Disorder of bone, unspecified

Calcium Levels: _____ Date: _____ Time: _____

SrCr: _____ Date: _____ Time: _____

BMD/T-Scores: _____ Location: _____ Date: _____

Is therapy new for patient? ❑ Yes ❑ No Is patient high risk? ❑ Yes ❑ No

Osteoportic fracture? ❑ Yes- Date: _____ Location: _____ ❑ No

FAX COPY OF ORTHOPEDIC SCANS AND ALL RELATED CLINICAL/LAB INFO

Prior Treatment/Therapy (If Any)	Reason for Discontinuation	Start and End Date of Therapy

MEDICAL RECONCILIATION

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

MEDICATION	DIRECTIONS	QTY	REFILLS
❑ BONIVA®	Inject the contents of 1 PFS intravenously every 3 months. To be administered by a healthcare professional.	1 PFS (3 mg/ 3mL)	
❑ FORTEO®	Inject 20 mcg subcutaneously once daily. Discard device 28 days after first use. Dispensed with BD Mini™ Pen Needles.	1 Pen (600 mcg/2.4mL) ❑ 1 Pen ❑ 3 Pens ❑ 100 needles	
❑ PROLIA®	Inject contents of 1 PFS subcutaneously every 6 months.	1 PFS (60 mg/1 mL)	
❑ RECLAST®	Infuse 5 mg intravenously over no less than 15 minutes once annually.* (Ready to infuse solution) **Administer in MD Office*	1 Vial (5 mg/100 mL)	

Injection Training Provided By: ❑ Physician's Office ❑ Delta Drugs | Ship to: ❑ Physician's Office ❑ Patient's Home | ❑ Dispense As Written

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

Physician's Signature: _____ Date: _____

I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.