Phone: 806-324-5447 • Toll Free Phone 1-866-629-6779
Toll Free Fax: 1-866-217-8034
E-mail: specialty@maxor.com • www.maxorspecialty.com

Osteoporosis Enrollment Form

Patient Information

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).

Medical Information (Please attach or complete all known medical history)

Diagnosis

☐731.0 Paget's Disease
☐733.00 Osteoporosis Unspecified
☐733.01 Postmenopausal Osteoporosis
☐733.02 Idiopathic Osteoporosis
☐733.09 Osteoporosis Other, Drug-induced
☐733.13 Pathological Fracture of Vertebrae
☐733.14 Pathological Fracture of Neck of Femur
☐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)______________________________

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

Shipping Information

☐New ☐Refill Date Medication Needed:__________

☐Injection Training Needed

Ship to: ☐Patient's Home ☐Physician's Office

☐Other______________________________

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
☐Boniva®	3 mg/3 ml (1 PFS)	Inject 3 mg IV over 15-30 seconds every 3 months		
☐Forteo®	600 mcg/2.4 ml 1 Pen and Supplies	Inject 20 mcg/0.8 ml SQ once daily		
☐Prolia®	60 mg/ml (1 PFS)	Inject 60 mg SQ once every 6 months		
☐Reclast®	5 mg/100 ml vial	☐Infuse 5 mg IV over no less than 15 minutes, every year ☐Infuse 5 mg IV over no less than 15 minutes, every two years		

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

©2013 Maxor NPSC All Rights Reserved.