Hy-Vee health

OSTEOPOROSIS
Therapy Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ Osteoporosis ☐ Paget's disease of bone ☐ Glucocorticoid-induced osteoporosis

☐ Disorder of bone (osteopenia) ☐ Other: _____

ICD-10 Code: _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Zoledronic Acid

☐ Zoledronic Acid 5 mg/100 mL IV x1 dose

Prolia

☐ Prolia 60 mg subcutaneous injection every 6 months x1 year

Evenity

☐ Evenity 210 mg subcutaneous injection once monthly x12 doses

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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COMPREHENSIVE SUPPORT FOR OSTEOPOROSIS THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to other therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of conventional therapy (i.e., oral and/or IV biphosphonate)? ☐ Yes ☐ No

  If yes, which drug(s)? _____

- ☐ Please indicate prior drug therapies: ☐ Boniva ☐ Forteo ☐ Reclast ☐ Prolia ☐ Actonel ☐ Evista ☐ Fosamax

  ☐ Other: _____

- ☐ Does the patient have a history of a minimal trauma fracture? ☐ Yes ☐ No

  If yes, location(s)? _____

- ☐ Patient is currently taking calcium/vitamin D supplementation ☐ Yes ☐ No

- ☐ Does the patient have a FRAX 10-year fracture probability of a major osteoporotic fracture at 20% or more OR a hip fracture at 3% or more? ☐ Yes ☐ No

☐ **Pretreatment** t-score: _____ (Osteoporosis: -2.5 or worse, Osteopenia: -1.0 or worse)

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____

Required Information

☐ **Serum calcium within 6 months (required for all therapies) – attach results**
☐ **Serum creatinine within 60 days (for Zoledronic Acid) – attach results**
☐ **Serum alkaline phosphatase (Paget's diagnosis) – attach results**
☐ **DEXA scan (osteo) – attach**
☐ **CT scan/X-ray (Paget's diagnosis) – attach**
☐ **Tried and failed therapies**

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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