TAMPA Family Pharmacy

Phone: 813-871-5161
Fax: 813-877-2479

Prolia Enrollment Form

PATIENT INFORMATION

Patient Name		Allergies ☐ NKDA	
Date of Birth	SSN#	Weight _____ ☐ kg ☐ lb Date	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address (optional)	

INSURANCE INFORMATION (PLEASE ATTACH A COPY OF THE FRONT AND BACK OF INSURANCE CARD)

Primary Insurance		Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

DIAGNOSIS INFORMATION (Please specify primary and secondary diagnoses)

Previous Therapy:
☐ Generic *Alendronate*
☐ Fosamax
☐ Actonel
☐ Boniva
☐ Other: _____

☐ 733.00 Osteoporosis, generalized ☐ 733.09 Osteoporosis, other
☐ 733.01 Osteoporosis, postmenopausal ☐ Other:_____

BMD/T-Score:_____

Is patient new to therapy? ☐ yes ☐ no Date of diagnosis

Previous Fracture: ☐ yes ☐ no If no, is pt at high risk: ☐ yes ☐ no

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Prolia (denosumab) injection	60mg	SC every 6 months	1 prefilled syringe	1

DELIVERY INSTRUCTIONS

☐ Physician Office ☐ Other injection site	☐ Other	Date Medication Needed
	Address	
	City/State/Zip	

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution:
Phone:	Fax	Specialty:
Address:	City/State/Zip:	
License #	NPI #	

Physician's Signature _____ **Date** _____