Publix Specialty Pharmacy #3213
BONE DISORDERS

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information
[Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _________________________ Patient's Last Name: __________________________ Date of Birth: ___/___/_____ ☐ Male ☐ Female

Address: ____ City: __________________________ State: ___________ Zip: __________________

Primary Phone Number: (_____) _______________ Alt. Phone Number: (_____) ____________________ Caregiver name: ___________________________

Clinical Information
[Attach copy of labs and clinical notes]

Diagnosis code: _______________ Diagnosis: ☐ Osteoporosis ☐ Bone metastases ☐ Other: ____

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ___/___/______ Weight: _______ ☐ kg ☐ lb Height: _______ ☐ cm ☐ in

BMD/T-score: ________ Date of T-score: ___/___/_____ Fracture history: ☐ None ☐ Site(s) and date(s): ___________________________________

Serum Creatinine: ________ mg/dL, CrCl: ________ mL/min, Serum Calcium: ________ mg/dL, Serum Albumin: ________ g/dL, Date of labs: ___/___/_____

Supplements: ☐ Calcium, dose: ____________________ ☐ Vitamin D, dose: ______________________ ☐ Neither, reason: ___________________________

Prior therapies, treatment dates, and reason for discontinuation: ____

Other pertinent past medical history and/or drug therapy: ____

Allergies: ☐ NKDA ☐ Other: ____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Boniva (ibandronate)	3 mg/3 mL prefilled syringe (PFS)	Infuse 3 mg IV over 15-30 seconds every 3 months	90 days	______
☐ Evenity (romosozumab)	105 mg/1.17 mL PFS	Inject 210 mg SC once a month	☐ 30 days ☐ 90 days	______
☐ Forteo (teriparatide) *Pen needles will be included unless otherwise specified.*	☐ 600 mcg/2.4 mL pen ☐ 620 mcg/2.48 mL pen *(generic)*	Inject 20 mcg SC once a day (discard device 28 days after first use)	☐ 28 days ☐ 84 days	______
☐ Prolia (denosumab)	60 mg/mL PFS	Inject 60 mg SC every 6 months	180 days	______
☐ Reclast (zoledronic acid)	5 mg/100 mL vial	☐ Infuse 5 mg IV over no less than 15 minutes once a year ☐ Other: ____	1 year	0
☐ Xgeva (denosumab)	120 mg/1.7 mL vial	☐ Inject 120 mg SC every 4 weeks ☐ Other: ____	☐ 28 days ☐ 84 days	______
☐ Zometa (zoledronic acid)	☐ 4 mg/100 mL vial ☐ 4 mg/5 mL vial *(concentrate)*	☐ Infuse 4 mg IV over no less than 15 minutes every 4 weeks	☐ 28 days ☐ 84 days	______
		☐ Infuse 4 mg IV over no less than 15 minutes every 3 weeks	☐ 21 days ☐ 42 days	
		☐ Other: ____	________	
☐ Other: ____________________	__________________________	____	________	______

Prescriber Information
[Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐ No ☐ Yes

Name: ____ DEA# ________________________ NPI # ______________________________________

Address: ____ City: __________________________ State: ___________ Zip: __________________

Office Phone Number: (_____) ________________ Fax Number: (_____) ______________________ Office Contact: ______________________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature:
(stamps not accepted)

____________________________________ ____________________________________

☐ Substitution allowed Date ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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