



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____
Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____
Address _____ City _____ State _____ ZIP _____
Cell phone _____ Other phone _____ Email _____
Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____
Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____
Practice _____ Specialty _____
Address _____ City _____ State _____ ZIP _____
Phone _____ Fax _____ Office contact _____
Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Diagnosis (ICD-10) ☐ M81.0 Age-related osteoporosis, no current fracture ☐ M81.8 Other osteoporosis (such as steroid-induced)
☐ M80.0 _____ Age-related osteoporosis with current fracture ☐ Other _____
T-scores: spine _____ Femoral neck _____ Total hip _____ DXA date _____
Past fractures ☐ Hip ☐ Spine ☐ Wrist ☐ Other _____ Fracture date _____
FRAX 10-year risk: major fracture _____ % Hip _____ % Calcium _____ Vitamin D _____
Tried before ☐ Alendronate ☐ Risedronate ☐ Ibandronate ☐ Zoledronic acid ☐ Denosumab ☐ Other _____
Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____
Reason for switching or stopping _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy
Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

Medication	Strength	Directions	Quantity	Refills
Injections				
☐ Forteo or teriparatide teriparatide, brand or generic	20 mcg/dose pen	Inject 20 mcg subcut once daily	1 pen	_____
☐ Evenity romosozumab-aqqg (given in the office)	105 mg/1.17 mL syringe	Inject 210 mg (2 syringes) monthly for 12 doses	2 syringes	_____
☐ Prolia denosumab (given in the office)	60 mg/mL syringe	Inject 60 mg subcut every 6 months	1 syringe	_____
☐ Denosumab biosimilar the plan's preferred biosimilar	60 mg/mL syringe	Inject 60 mg subcut every 6 months	1 syringe	_____
Tablets				
☐ Alendronate Fosamax generic	70 mg tablet	1 tablet weekly, 30 min before breakfast, with water	4 tablets	_____
☐ Risedronate Actonel generic	35 mg tablet	1 tablet weekly, 30 min before breakfast, with water	4 tablets	_____
☐ Ibandronate Boniva generic	150 mg tablet	1 tablet monthly, 60 min before breakfast, with water	1 tablet	_____
☐ Raloxifene Evista generic	60 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
Other medication (write in)				
☐ _____	_____	_____	_____	_____
☐ _____	_____	_____	_____	_____

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.