Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS

Osteoporosis

1204 SE 28th St, Suite 2
Bentonville, AR 72712
Phone: 844-414-5805
Fax: 855-422-2400 / 479-464-8838

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):_____ Date Needed:_____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	Tax ID#:
Sex: ❑ Male ❑Female Weight lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis

❑ M81.0 Age related osteoporosis without current pathological fracture

❑ M81.8 Other osteoporosis without current pathological fracture

❑Other_____ ICD-10 code: _____

Date of diagnosis (or years with disease) _____

Is the patient postmenopausal? ❑ Yes ❑ No

Bone Mineral Density (BMD)/T-Score:_____ **Date:** _____

Current or History of Fractures? ❑ Yes ❑ No **Date(s):** _____

Prior and Current Treatment *(please attach list if necessary)*

Is the patient currently receiving treatment or previously been treated for the diagnosis indicated? ❑Yes ❑No

❑ _____ Length of therapy: _____ Outcome: _____

❑ _____ Length of therapy: _____ Outcome: _____

❑ _____ Length of therapy: _____ Outcome: _____

Does the patient have any contraindications or intolerances to any medications? ❑Yes ❑No

If yes, please name medication and describe contraindication or reaction? _____

PRESCRIPTION

DRUG	DIRECTIONS	QUANTITY	DOSAGE FORM	REFILLS
Evenity®	❑ Inject 210mg subcutaneously once monthly.	❑ 2 x 1.17mL	❑ 105mg/1.17mL PFS	
Forteo®	❑ Inject 20mcg subcutaneously once daily.	❑ 1 x 2.4mL ❑ 3 x 2.4mL	❑ 600mcg/2.4mL	
Prolia®	❑ Inject 60mg subcutaneously every 6 months. Bring to office for administration.	❑ 1 syringe	❑ 60mg/mL PFS	
31G Pen Needles	❑ Use with Forteo® delivery device as directed.	❑ 100 ct	❑ 5mm ❑ 8mm	

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.*

Date: _____ _____ _____

DISPENSE AS WRITTEN **MAY SUBSTITUTE**