

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name:		Prescriber Name:	
Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female		DEA: _____ NPI _____	Date: <input type="text"/>
SSN: _____		Address: _____	Need Date: <input type="text"/>
Address: _____		Phone _____ Fax: _____	
Phone: _____		Contact Person: _____	

INSURANCE INFORMATION	CLIENT INFO
Please fax a copy (front and back) of patients current active Insurance and ID cards.	Weight : _____ Height: _____

**CLINICAL INFORMATION - Please provide most recent lab reports**

**Diagnosis:**

Senile Osteoporosis M81.0 \_\_\_\_\_ Fracture History \_\_\_\_\_ Location: \_\_\_\_\_

Osteoporosis M81.8 \_\_\_\_\_ T- Score \_\_\_\_\_ Other Risk Factors: \_\_\_\_\_

**History of Prior Therapy**

Alendronate                       Fosamax                       Reclast  
 Boniva                                 Actonel                       Steroids  
 Atelvia                                  Miacacin NS                 Other \_\_\_\_\_

Reason for discontinuing previous therapy: \_\_\_\_\_

Contraindications: \_\_\_\_\_

Other patient medical information (such as supplements {list}): \_\_\_\_\_


MEDICATION	STRENGTH	SIG / DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> PROLIA	60 mg / ml	Inject 60 mg SQ Every 6 months	1	
<input type="checkbox"/> Other				
<input type="checkbox"/> Other				
<input type="checkbox"/> Other				

**Prescription Information**

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Bella Vida Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**email us: tech@BellavidaPharmacy.com**



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