



valeda
HEALTH

250 Mount Lebanon Blvd, Suite 208
Pittsburgh, PA 15234
Main: (844) 698-2533 Fax: (844) 733-3779

Navigating your journey with compassionate wisdom

OSTEOPOROSIS

Fax to: **(844) ReferRx**
733-3779

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.
Please contact your Valeda team if you have any questions and/or concerns at (844) 698-2533

1 Patient Information

Patient Name: _____ Phone: _____ Date Medication Needed: _____
Soc. Sec. #: _____ DOB: _____ Email: _____ Ship To: Patient's Home Prescriber's Office
Address: _____ City: _____ State: _____ ZIP: _____

Alternate Caregiver Information

Alternate Caregiver Name: _____ Phone: _____ Email: _____

2 Prescriber Information

Provider Name: _____ Practice Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____ NPI#: _____ DEA: _____ Tax ID#: _____

Practice Contact Information

Practice Contact: _____ Phone: _____ Email: _____

3 Clinical Information

PLEASE FAX (1) Therapy regimen(s) / schedule, (2) last clinical notes and (3) lab values/scans -- (current and past)

Diagnosis: _____ ICD-10: _____ Sex: ☐ M ☐ F Height: _____ Weight: _____ lbs. kg.
(circle one) (circle one)

4 Insurance Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Medication	Dose/Strength	Directions	Qty.	Refills
Boniva®	3mg/mL Syringe	Infuse 3mg IV over 15-30 seconds once every 3 months	1 Syringe (12 week supply)	
Forteo®	2.4mL Multi Dose Pen	Inject 20mcg SQ once every day	1 Pen (28 day supply)	
Prolia®	60mg/mL Syringe	Inject 60mg SQ once every 6 months	1 Syringe (180 day supply)	
Reclast®	5mg/100mL vial	Infuse 5mg IV over at least 15 minutes once yearly	1 Vial (365 day supply)	No Refills
Tymlos®	1.56mL Multi Dose Pen	Inject 80mcg SQ once every day	1 Pen (30 day supply)	
Calcium Carb/Vitamin D3	600mg/400IU	Take 1 tablet by mouth twice daily Other:	180 Tabs (90 day supply)	
	600mg/200IU	Take 1 tablet by mouth twice daily Other:	180 Tabs (90 day supply)	
OTHER	Dose / Strength:	Directions:	Qty:	Refills:

PATIENT SUPPORT PROGRAMS:

Please sign and date to the right to enroll in the pharmaceutical company assisted patient support program

PATIENT SIGNATURE REQUIRED

Signature

Date

This prescription will be filled generically unless the prescriber handwrites "Brand Medically Necessary" or your state specific required language to prohibit substitution:

Prescriber, please sign and date below

PHYSICIAN SIGNATURE REQUIRED

Signature

Date

I authorize Valeda RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE:

This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OK/MONT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____