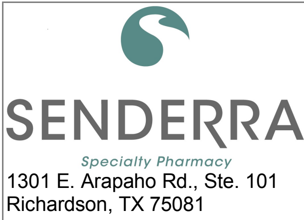
Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

Endocrine Disorders Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescribing Practitioner:		**NPI:**
Supervising Physician:		**NPI:**
Address:		**Tax ID:**
Office:	Fax:	
Contact:		

PATIENT INFORMATION

Name:		☐ M ☐ F	DOB: ____/____/________	SS#: ____-____-________
Street:	City:		State:	ZIP:
Tel:	Alt. Tel:	☐ English ☐ Spanish ☐ Other: ________		Wt.: ________ Ht.: ________

PRESCRIPTION

☐ **New** ☐ **Refill**	**Ship by:** ____/____/________	**Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** ________________

Drug		**Directions & Quantity**	**Refills**
Genotropin®	☐ 5 mg cartridge ☐ 12 mg cartridge ☐ Miniquick® _____mg cartridge		
Humatrope®	☐ 5 mg vial ☐ 12 mg cartridge ☐ 6 mg cartridge ☐ 24 mg cartridge		
Increlex®	☐ 40 mg/4 mL vial		
Lupron Depot-PED®	☐ 7.5 mg ☐ 11.25 mg ☐ 15 mg		
Norditropin FlexPro®	☐ 5 mg/1.5 mL ☐ 15 mg/1.5 mL ☐ 10 mg/1.5 mL ☐ 30 mg/3 mL		
Nutropin AQ®	☐ 10 mg/2 mL cartridge ☐ 20 mg/2 mL cartridge ☐ 5 mg/2 mL NuSpin® ☐ 10 mg/2 mL NuSpin® ☐ 20 mg/2 mL NuSpin®		
Omnitrope®	☐ 5 mg/1.5 mL cartridge ☐ 10 mg/1.5 mL cartridge ☐ 5.8 mg vial		
Saizen®	☐ 5 mg vial ☐ 8.8 mg click.easy® ☐ 8.8 mg vial ☐ 8.8 mg saizenprep®		
Sandostatin®			
Sandostatin® LAR Depot			
Serostim®	☐ 4 mg vial ☐ 5 mg vial ☐ 6 mg vial		
Somavert®	☐ 10 mg vial ☐ 15 mg vial ☐ 20 mg vial ☐ 25 mg vial ☐ 30 mg vial		
Zomacton®	☐ 5 mg vial ☐ 10 mg vial w/ 25G reconstitution needle ☐ 10 mg vial w/ vial adapter		
Zorbtive®	☐ 8.8 mg vial		

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Reason(s) for Discontinuing**
☐ ____________________	☐ (______________)	☐	____________________
☐ ____________________	☐ (______________)	☐	____________________
☐ ____________________	☐ (______________)	☐	____________________

Date of Diagnosis: ____/____/________ Allergies: ______________________________

☐ C73 Malignant Neoplasm	☐ E89.3 Postprocedural Hypopituitarism	☐ N08 Glomerular disorders in diseases classified elsewhere
☐ E22.0 Acromegaly	☐ Q95.9 Turner's Syndrome, unspecified	☐ N28.9 Disorder of Kidney and Ureter, unspecified
☐ E23.0 Hypopituitarism	☐ E23.1 Drug induced Hypopituitarism	☐ P05.00 Newborn light for gestational age, unspecified weight
☐ R62.52 Short Stature	☐ N18.9 Chronic Kidney disease, unspecified	☐ P05.10 Newborn small for gestational age, unspecified weight
☐ R64 Cachexia	☐ Q99.8 Other specified Chromosome	☐ Q87.1 Congenital malformation syndromes predominantly associated with short stature
☐ E30.1 Precocious Puberty	☐ Other: ______________________________	

Additional Clinical Information:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner:	**Date**: ______/______/__________

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should 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.