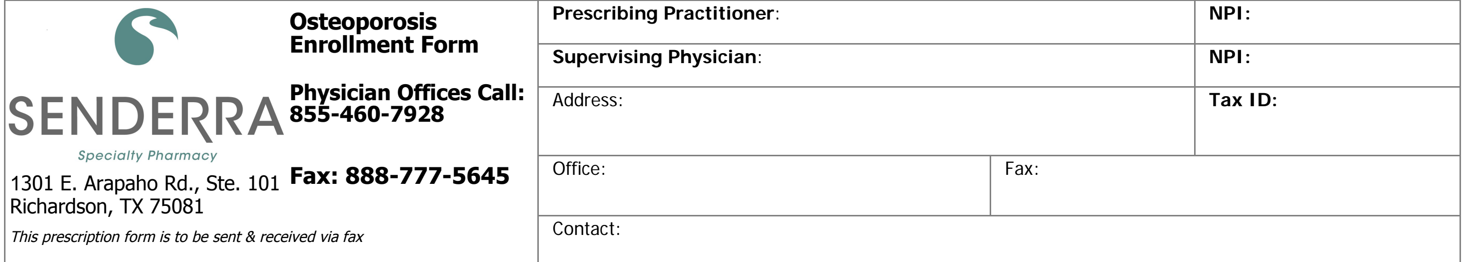
Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



Osteoporosis Enrollment Form

SENDERRA Specialty Pharmacy

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

This prescription form is to be sent & received via fax

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#: _____-_____-__________
Tel:	Al. Tel:	☐ English ☐ Spanish ☐ Other: ________		Wt.: ________ Ht.: ________
Street:	City:	State:	ZIP:	

MEDICAL INFORMATION

Prior Failed Medication(s):	**Length of Treatment:**	**Reason for Discontinuing:**
Actonel	______/______/_______-______/______/_______	
Boniva	______/______/_______-______/______/_______	
Fosamax	______/______/_______-______/______/_______	
Prolia	______/______/_______-______/______/_______	
Reclast	______/______/_______-______/______/_______	

☐ **Patient has not tried or failed any prior medication(s).**

Diagnosis Date: ________/________/__________
- ☐ M80.0 Age Related Osteoporosis with Fracture
- ☐ M80.8 Other Osteoporosis with Fracture
- ☐ M81.0 Age Related Osteoporosis without Fracture (Senile/Postmenopausal)
- ☐ M81.6 Localized Osteoporosis
- ☐ M81.8 Other Osteoporosis without Fracture
- ☐ M85.9 Disorder of Bone Density and Structure, Unspecified (Osteopenia)
- ☐ M89.9 Disorders of Bone, Unspecified
- ☐ M84.48XA to M84.40XA Pathological Fracture, Unspecified Site
- ☐ Other: ____

Lowest Dexa T-score: ________ Site: ________ Date: _____/_____/_____

Fracture Site(s): ________ Date: _____/_____/_____

Allergies:

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

PRESCRIPTION

☐ **New** ☐ **Refill** | **Ship by:** ____/____/____ | **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** ____________________

Drug		**Directions**	**Quantity**	**Refills**
Boniva®	☐ Pre-filled Syringe	☐ Inject 3mg IV over 15-30 seconds every 3 months	3mg/3ml (1 syringe)	
Forteo®	☐ Pen	Inject 20mcg SQ daily	600mcg/2.4ml (1 pen)	
		☑ **Pen needles**: Use with Forteo daily as directed	30 days supply	
Prolia®	☐ Pre-filled Syringe	☐ Inject 60mg SQ once every 6 months	60mg/ml (1 syringe)	
Reclast® (Zoledronic Acid)	☐ Vial	☐ Infuse 5mg IV, over no less than 15 minutes, every year ☐ Infuse 5mg IV, over no less than 15 minutes, ever two years	1 vial	

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Senderra to coordinate injection training

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.