

 <p>SENDERRA Specialty Pharmacy 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent & received via fax</i></p>	Endocrine Disorders Enrollment Form Physician Offices Call: 855-460-7928 Fax: 888-777-5645		Prescriber: Supervising Physician: Address: Phone: Fax: Contact:	NPI: NPI: Tax ID:
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PATIENT INFORMATION				
Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: / /	SS#: - -	
Street:	City:	State: / /	ZIP: - -	
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: / /	Wt.: / /	Ht.: / /

PRESCRIPTION			
<input type="checkbox"/> New <input type="checkbox"/> Refill	Ship by: / / /	Ship to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: / /	
Drug	Directions & Quantity	Refills	
Genotropin®	<input type="checkbox"/> 5 mg cartridge <input type="checkbox"/> 12 mg cartridge <input type="checkbox"/> Miniquick® mg cartridge		
Humatrope®	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 12 mg cartridge <input type="checkbox"/> 6 mg cartridge <input type="checkbox"/> 24 mg cartridge		
Lupron Depot-PED®	<input type="checkbox"/> 7.5 mg <input type="checkbox"/> 11.25 mg <input type="checkbox"/> 15 mg		
Norditropin FlexPro®	<input type="checkbox"/> 5 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 30 mg		
Nutropin AQ®	<input type="checkbox"/> 5 mg NuSpin® <input type="checkbox"/> 10 mg NuSpin® <input type="checkbox"/> 20 mg NuSpin®		
Omnitrope®	<input type="checkbox"/> 5 mg cartridge <input type="checkbox"/> 10 mg cartridge <input type="checkbox"/> 5.8 mg vial		
Saizen®	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 8.8 mg Saizenprep® <input type="checkbox"/> 8.8 mg vial		
Sandostatin®			
Sandostatin® LAR Depot			
Skytrofa®	<input type="checkbox"/> 3 mg cartridge <input type="checkbox"/> 3.6 mg cartridge <input type="checkbox"/> 4.3 mg cartridge <input type="checkbox"/> 5.2 mg cartridge <input type="checkbox"/> 6.3 mg cartridge <input type="checkbox"/> 7.6 mg cartridge <input type="checkbox"/> 9.1 mg cartridge <input type="checkbox"/> 11 mg cartridge <input type="checkbox"/> 13.3 mg cartridge		
Zomacton®	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 10 mg vial w/ 25G reconstitution needle <input type="checkbox"/> 10 mg vial w/ vial adapter		
Zorbtive®	<input type="checkbox"/> 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: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Tried & Failed (Duration): <input type="checkbox"/> () <input type="checkbox"/> () <input type="checkbox"/> ()	Not Tolerated: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Reason(s) for Discontinuing _____ _____ _____
Date of Diagnosis: / /		Allergies:	
<input type="checkbox"/> C73 Malignant Neoplasm <input type="checkbox"/> E22.0 Acromegaly <input type="checkbox"/> E23.0 Hypopituitarism <input type="checkbox"/> R62.52 Short Stature <input type="checkbox"/> R64 Cachexia <input type="checkbox"/> E30.1 Precocious Puberty	<input type="checkbox"/> E89.3 Postprocedural Hypopituitarism <input type="checkbox"/> Q95.9 Turner's Syndrome, unspecified <input type="checkbox"/> E23.1 Drug induced Hypopituitarism <input type="checkbox"/> N18.9 Chronic kidney disease, unspecified <input type="checkbox"/> Q99.8 Other specified chromosome <input type="checkbox"/> Other: / /	<input type="checkbox"/> N08 Glomerular disorders in diseases classified elsewhere <input type="checkbox"/> N28.9 Disorder of kidney and ureter, unspecified <input type="checkbox"/> P05.00 Newborn light for gestational age, unspecified weight <input type="checkbox"/> P05.10 Newborn small for gestational age, unspecified weight <input type="checkbox"/> Q87.1 Congenital malformation syndromes predominantly associated with short stature	
Additional Clinical Information: _____ _____ _____			

PRESCRIBER SIGNATURE	
To Prescriber: 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.	
Prescriber: / /	Date: / /
CONFIDENTIALITY NOTICE	
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