

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



SENDERRA

Specialty Pharmacy
3712 E. Plano Parkway, Ste. 200
Plano, TX 75074

This prescription form is to be sent & received via fax

Endocrine Disorders Enrollment Form

Physician Offices Call:
855-460-7928

Fax: 888-777-5645

Prescriber:		NPI:
Supervising Physician:		NPI:
Address:		Tax ID:
Phone:	Fax:	
Contact:		

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"/> 6 mg cartridge <input type="checkbox"/> 12 mg cartridge			
Lupron Depot-PED® <input type="checkbox"/> 7.5 mg (1-month) <input type="checkbox"/> 11.25 mg (1-month) <input type="checkbox"/> 11.25 mg (3-month) <input type="checkbox"/> 15 mg (1-month) <input type="checkbox"/> 30 mg (3-month) <input type="checkbox"/> 45 mg (6-month)			
Ngenia® <input type="checkbox"/> 24 mg Pen <input type="checkbox"/> 60 mg Pen			
Norditropin FlexPro® <input type="checkbox"/> 5 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 10 mg			
Omnitrope® <input type="checkbox"/> 5 mg cartridge <input type="checkbox"/> 10 mg cartridge <input type="checkbox"/> 5.8 mg vial			
Sandostatin®			
Sandostatin® LAR Depot <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg			
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			
Sogroya® <input type="checkbox"/> 5 mg Pen <input type="checkbox"/> 10 mg Pen <input type="checkbox"/> 15 mg Pen			
Zomacton® <input type="checkbox"/> 5 mg vial <input type="checkbox"/> 10 mg vial w/ 25G reconstitution needle			
Pen Needle ____ G X ____ length (in)	Use 1 pen needle as directed	QS x 1 month	

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
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____

Date of Diagnosis: ____/____/____	Allergies:
<input type="checkbox"/> C73 Malignant Neoplasm	<input type="checkbox"/> E89.3 Postprocedural Hypopituitarism
<input type="checkbox"/> E22.0 Acromegaly	<input type="checkbox"/> Q95.9 Turner's Syndrome, unspecified
<input type="checkbox"/> E23.0 Hypopituitarism	<input type="checkbox"/> E23.1 Drug induced Hypopituitarism
<input type="checkbox"/> R62.52 Short Stature	<input type="checkbox"/> N18.9 Chronic kidney disease, unspecified
<input type="checkbox"/> R64 Cachexia	<input type="checkbox"/> Q99.8 Other specified chromosome
<input type="checkbox"/> E30.1 Precocious Puberty	<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

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.