



**SENDERRA**

Specialty Pharmacy

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

This prescription form is to be sent & received via fax

**Osteoporosis Enrollment Form**

Physician Offices Call:  
855-460-7928

Fax: 888-777-5645

<b>Prescriber:</b>		<b>NPI:</b>
<b>Supervising Physician:</b>		<b>NPI:</b>
Address:		<b>Tax ID:</b>
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**

New  Refill Ship by: / / SHIP TO:  Patient's Home  Doctor's Office  Other: \_\_\_\_\_

Drug	Directions & Quantity	Refills
<b>Forteo®</b> (teriparatide)	<input type="checkbox"/> 560 mcg/2.24 mL Pen <input type="checkbox"/> Inject 20 mcg SQ daily (Quantity: 1) <input checked="" type="checkbox"/> Pen needles (31G x 3/16"): Use one pen needle with each daily dose of Forteo as directed (Quantity: 28)	
<b>Teriparatide</b>	<input type="checkbox"/> 560 mcg/2.24 mL Pen <input type="checkbox"/> Inject 20 mcg SQ daily (Quantity: 1) <input checked="" type="checkbox"/> Pen needles (31G x 3/16"): Use one pen needle with each daily dose of teriparatide as directed (Quantity: 28)	
<b>Reclast®</b> (zoledronic acid)	<input type="checkbox"/> 5 mg Vial <input type="checkbox"/> Infuse 5 mg via IV over no less than 15 minutes every year (Quantity: 1) <input type="checkbox"/> Infuse 5 mg via IV over no less than 15 minutes every two years (Quantity: 1)	

**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:	Contraindication:
<input type="checkbox"/> Actonel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Boniva	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Fosamax	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Prolia	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Reclast	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____

<input type="checkbox"/> M80.00XA Age-related osteoporosis with current pathological fracture, unspec. site, initial encounter for fracture	<input type="checkbox"/> M80.80XA Other osteoporosis with current pathological fracture, unspec. site, initial encounter for fracture
<input type="checkbox"/> M81.0 Age-related osteoporosis without current pathological fracture	<input type="checkbox"/> M81.6 Localized Osteoporosis
<input type="checkbox"/> M81.8 Other Osteoporosis without current pathological fracture	<input type="checkbox"/> M85.8 Other specified disorders of bone density and structure, unspec. Site (Osteopenia)
<input type="checkbox"/> M84.40XA Pathological fracture, unspec. site, initial encounter for fracture	<input type="checkbox"/> M84.459A Pathological fracture, hip, unspec., initial encounter for fracture
<input type="checkbox"/> M8 _____	<input type="checkbox"/> Other: _____

Date of Diagnosis: / / Allergies: \_\_\_\_\_

Lowest DEXA T-Score: Site: Date: / / Fracture Site(s): Date: / /

**Additional Clinical Information:**

**INJECTION TRAINING**

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

**PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED**

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.

<b>PRODUCT SUBSTITUTION PERMITTED</b>	<b>DISPENSE AS WRITTEN</b>
X _____ Date: / /	X _____ 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.