



SENDERRA

Specialty Pharmacy

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

This prescription form is to be sent & received via fax

Osteoporosis 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	
Boniva® <i>(ibandronate)</i>	<input type="checkbox"/> 3 mg Pre-filled Syringe <input type="checkbox"/> Inject 3 mg IV over 15-30 seconds every 3 months (Quantity: 1)		
Forteo®	<input type="checkbox"/> 600 mcg/2.4 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)		
Prolia®	<input type="checkbox"/> 60 mg Pre-filled Syringe <input type="checkbox"/> Inject 60 mg SQ once every 6 months (Quantity: 1)		
Reclast® <i>(Zoledronic Acid)</i>	<input type="checkbox"/> 5 mg Vial <input type="checkbox"/> Infuse 5 mg IV over no less than 15 minutes every year (Quantity: 1) <input type="checkbox"/> Infuse 5 mg 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.

PRODUCT SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN
X _____ Date: ___/___/___	X _____ Date: ___/___/___

CONFIDENTIALITY NOTICE

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