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

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:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ___/___/_____	SS#: ___-___-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

☐ **New** ☐ **Refill** **Ship by:** ___/___/_____ **SHIP TO:** ☐**Patient's Home** ☐**Doctor's Office** ☐**Other:** _____

Drug		Directions & Quantity	Refills
Boniva® *(ibandronate)*	☐ 3 mg Pre-filled Syringe	☐ Inject 3 mg via IV over 15-30 seconds every 3 months (Quantity: 1)	
Forteo®	☐ 600 mcg/2.4 mL Pen	☐ Inject 20 mcg SQ daily (Quantity: 1)	
		☑ **Pen needles (31G x 3/16"):** Use one pen needle with each daily dose of Forteo as directed (Quantity: 28)	
Prolia®	☐ 60 mg Pre-filled Syringe	☐ Inject 60 mg SQ once every 6 months (Quantity: 1)	
Reclast® *(zoledronic acid)*	☐ 5 mg Vial	☐ Infuse 5 mg via IV over no less than 15 minutes every year (Quantity: 1)	
		☐ 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:
☐ Actonel	☐(_____)	☐	_____
☐ Boniva	☐(_____)	☐	_____
☐ Fosamax	☐(_____)	☐	_____
☐ Prolia	☐(_____)	☐	_____
☐ Reclast	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

☐ M80.00XA Age-related osteoporosis with current pathological fracture, unspec. site, initial encounter for fracture

☐ M80.80XA Other osteoporosis with current pathological fracture, unspec. site, initial encounter for fracture

☐ M81.0 Age-related osteoporosis without current pathological fracture

☐ M81.6 Localized Osteoporosis

☐ M81.8 Other Osteoporosis without current pathological fracture

☐ M85.8 Other specified disorders of bone density and structure, unspec. Site (Osteopenia)

☐ M84.40XA Pathological fracture, unspec. site, initial encounter for fracture

☐ M84.459A Pathological fracture, hip, unspec., initial encounter for fracture

☐ M8___.____ _____

☐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

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.