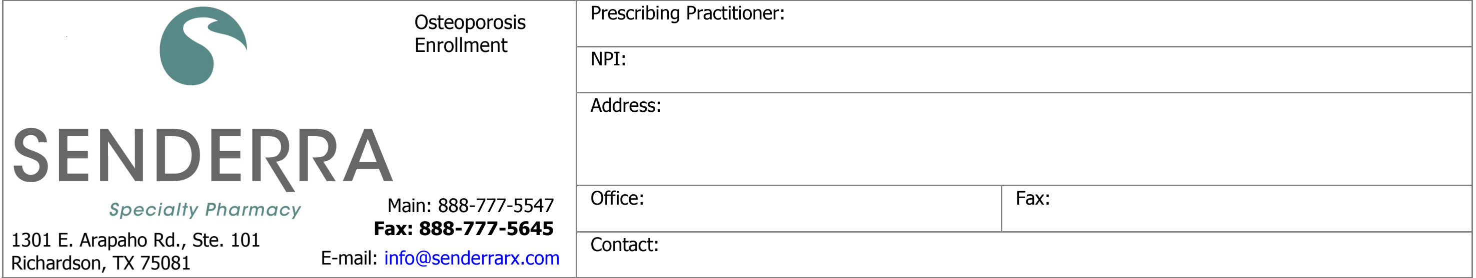
Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



Osteoporosis Enrollment

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

Main: 888-777-5547
Fax: 888-777-5645
E-mail: info@senderrarx.com

Prescribing Practitioner:	
NPI:	
Address:	
Office:	Fax:
Contact:	

PATIENT INFORMATION

Name:		☐ M ☐ F	DOB: ____/____/________	SS#: ____-____-________	
Tel:	Al. Tel:	☐ English ☐ Spanish ☐ Other: ________		Wt.: ________	Ht.: ________
Street:	City:	State:	ZIP:		

MEDICAL INFORMATION

Prior Failed Medication(s):	Length of Treatment:	Reason for Discontinuing:
	______/______/________-______/______/________	
	______/______/________-______/______/________	
	______/______/________-______/______/________	

Diagnosis Date: ________/________/__________

- M81.0 Postmenopausal/Senile Osteoporosis
- M81.8 Drug-induced Osteoporosis
- M88.9 Paget's Disease
- M89.9 Other and Unspecified disorder of bones and cartilage
- M84.48XA Pathological Fracture of Vertebrae
- M84.459A Pathological Fracture of Neck of Femur
- T50.905A Unspecified adverse effect of other drug, medicinal and biological substance
- Other: ____________________________

Lowest Dexa T-score: ________ Site: ________ Date: _____/_____/_____

Fracture Site(s): ________ Date: _____/_____/_____

Allergies:

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY LAB NOTES REGARDING THERAPY

PRESCRIPTION

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

Drug		Directions	Quantity	Refills
Boniva®	Pre-filled Syringe	Inject 3mg IV over 15-30 seconds every 3 months	3mg/3ml (1 syringe)	
Forteo®	Pen	Inject 20mcg SQ daily	600mcg/2.4ml (1 pen)	
		☑ **Pen needles**: Use with Forteo daily as directed	30 days' supply	
Prolia®	Pre-filled Syringe	Inject 60mg SQ once every 6 months	60mg/ml (1 syringe)	
Reclast®	Vial	Infuse 5mg IV, over no less than 15 minutes, every year Infuse 5mg IV, over no less than 15 minutes, ever two years	5mg/100ml (1 vial)	

INJECTION TRAINING

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

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Senderra Rx to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner:	**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.