


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.

 SENDERRA <i>Specialty Pharmacy</i> 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 Main Tel: 888-777-5547 Fax: 888-777-5645	Orthopedic Enrollment	Prescribing Practitioner:	NPI:
		Supervising Physician:	NPI:
	Address:		
	Office:	Fax:	
	Contact:		

PATIENT INFORMATION					
Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____/_____/_____	SS#: _____-____-____		
Tel: _____	Al. Tel: _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: _____	Ht.: _____	
Street: _____	City: _____	State: _____	ZIP: _____		

MEDICAL INFORMATION	
Forteo T-Score: _____ Site: _____ Date: _____ Fracture History Site: _____ Date: _____ Current Medications _____ Referring PCP _____ Prior Failed Medications <input type="checkbox"/> Actonel Length of Treatment: _____ - _____ Reason for Discontinuing: _____ <input type="checkbox"/> Boniva Length of Treatment: _____ - _____ Reason for Discontinuing: _____ <input type="checkbox"/> Fosamax Length of Treatment: _____ - _____ Reason for Discontinuing: _____ <input type="checkbox"/> Prolia Length of Treatment: _____ - _____ Reason for Discontinuing: _____ <input type="checkbox"/> Reclast Length of Treatment: _____ - _____ Reason for Discontinuing: _____ <input type="checkbox"/> Patient has not tried or failed any prior medication(s).	Enroll into Forteo Connect ongoing personalized support? <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date of Therapy ____/____/____ (Forteo is not to exceed 2 years of therapy) <input type="checkbox"/> Initiation of Therapy <input type="checkbox"/> Continuation of Therapy

Diagnosis Date: ____/____/____	<input type="checkbox"/> M80.0 Age Related Osteoporosis with Fracture <input type="checkbox"/> M80.8 Other Osteoporosis with Fracture <input type="checkbox"/> M81.0 Age Related Osteoporosis without Fracture (Senile/Postmenopausal) <input type="checkbox"/> M81.6 Localized Osteoporosis <input type="checkbox"/> M81.8 Other Osteoporosis without Fracture	<input type="checkbox"/> M85.9 Disorder of Bone Density and Structure, Unspecified (Osteopenia) <input type="checkbox"/> M89.9 Disorders of Bone, Unspecified <input type="checkbox"/> M84.48XA to M84.40XA Pathological Fracture, Unspecified Site <input type="checkbox"/> Other: _____
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PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD FRONT AND BACK AS WELL AS ANY LAB NOTES REGARDING THERAPY

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	
<input type="checkbox"/> Forteo®	Pen	Inject 20 mcg SQ daily	600mcg/2.4mL (1 pen)	
	<input checked="" type="checkbox"/> Pen needles: Use with Forteo daily as directed		30 days' supply	

INJECTION TRAINING
<input type="checkbox"/> Patient has received pen and injection training <input type="checkbox"/> Physician's office to provide injection training <input type="checkbox"/> 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: ____/____/____
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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.