


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.

 <p>1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081</p> <p><i>This prescription form is to be sent &amp; received via fax</i></p>	<b>Asthma Enrollment Form</b>	<b>Prescribing Practitioner:</b>		<b>NPI:</b>
	<b>Physician Offices Call: 855-460-7928</b>	<b>Supervising Physician:</b>		<b>NPI:</b>
	<b>Fax: 888-777-5645</b>	Address:		<b>Tax ID:</b>
		Office:	Fax:	
		Contact:		

PATIENT INFORMATION					
Name:		<input type="checkbox"/> M <input type="checkbox"/> F	DOB: ____/____/____	SS#: ____-____-____	
Street:		City:	State:	ZIP:	
Tel:	Alt. Tel:	<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	Strength	Directions & Quantity	Refills
<b>Dupixent®</b>	<input type="checkbox"/> 200 mg Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 400 mg SQ (two 200 mg injections) SQ on day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 200 mg SQ every <b>other</b> week starting at day 15 (Quantity: 2)	
	<input type="checkbox"/> 300 mg Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ (two 300 mg injections) SQ on day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every <b>other</b> week starting at day 15 (Quantity: 2)	
<b>Nucala®</b>	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Inject 100 mg SQ once every 4 weeks (Quantity: 1)	

MEDICAL INFORMATION			
<b>***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY***</b>			
<b>PREVIOUS THERAPIES:</b>	<b>Tried &amp; Failed (Duration):</b>	<b>Not Tolerated:</b>	<b>Reason(s) for Discontinuing</b>
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
IgE Level: _____ Date: ____/____/____      Number of severe exacerbations past 12 months: _____			
Eosinophil levels: _____ cells/mcL Date: ____/____/____ <input type="checkbox"/> Patient has moderate to severe asthma that requires add-on maintenance treatment			
<input type="checkbox"/> Inhaled corticosteroids (without LABA) are inappropriate for this patient		<input type="checkbox"/> Oral and/or injectable corticosteroids are inappropriate for this patient	
<input type="checkbox"/> Combination therapy (ICS/LABA) is inappropriate for this patient		<input type="checkbox"/> Other controllers are inappropriate for this patient Explain/specify: _____	
<b>Date of Diagnosis:</b> ____/____/____		<b>Allergies:</b> _____	
<input type="checkbox"/> J45.40 Moderate Persistent Asthma, uncomplicated	<input type="checkbox"/> J45.41 Moderate Persistent Asthma w/ acute exacerbation	<input type="checkbox"/> J45.50 Severe Persistent Asthma, uncomplicated	
<input type="checkbox"/> J45.51 Severe Persistent Asthma w/ acute exacerbation	<input type="checkbox"/> Other: _____		
<b>Additional Clinical Information:</b>			

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 to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE	
<b>To Prescribing Practitioner:</b> 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>Prescribing Practitioner:</b> _____	<b>Date:</b> ____/____/____

CONFIDENTIALITY NOTICE
<b>IMPORTANT:</b> 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.