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
Specialty Pharmacy
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent & received via fax

Asthma Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Office:	Fax:
Contact:	

PATIENT INFORMATION

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

PRESCRIPTION

☐ **New** ☐ **Refill** **Ship by:** ____/____/_____ **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug	Strength	Directions & Quantity	Refills
Dupixent®	☐ 200 mg Pre-filled Syringe	☐ **INITIAL:** Inject 400 mg SQ (two 200 mg injections) SQ on day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week starting at day 15 (Quantity: 2)	
	☐ 300 mg Pre-filled Syringe	☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections) SQ on day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2)	
Nucala®	☐ 100 mg Vial	☐ Inject 100 mg SQ once every 4 weeks (Quantity: 1) ☐ Inject 300 mg SQ once every 4 weeks (Quantity: 3)	

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:	Reason(s) for Discontinuing
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

IgE Level: _____ Date: _____/_____/_____

Eosinophil levels: _____cells/mcL Date: _____/_____/_____

☐ Inhaled corticosteroids (without LABA) are inappropriate for this patient

☐ Combination therapy (ICS/LABA) is inappropriate for this patient

Number of severe exacerbations past 12 months: _____

☐ Patient has moderate to severe asthma that requires add-on maintenance treatment

☐ Oral and/or injectable corticosteroids are inappropriate for this patient

☐ Other controllers are inappropriate for this patient Explain/specify:_____

Date of Diagnosis: _____/_____/_____

Allergies:_____

☐ J45.40 Moderate Persistent Asthma, uncomplicated

☐ J45.41 Moderate Persistent Asthma w/ acute exacerbation

☐ J45.50 Severe Persistent Asthma, uncomplicated

☐ J45.51 Severe Persistent Asthma w/ acute exacerbation

☐ Other: _____

Additional Clinical Information:

INJECTION TRAINING

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

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: 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.

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.