SENDERRA
Specialty Pharmacy

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

*This prescription form is to be sent & received via fax*

**Asthma/Respiratory 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

**Has the patient received a loading dose/starter kit?** ☐ **Yes Start Date:** ____/____/______ ☐ **No** **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

| Drug | Strength | Directions & Quantity | Refills |
|---|---|---|---|
| **HP Acthar® Gel** | ☐ 5 mL multi-dose vial | **Dose:** ___________ ☐Units ☐ mL; **Route of Administration:** ☐IM ☐ SQ; **Schedule/Frequency:** ______________ ______________; **Quantity of Vials:** | |
| **Dupixent®** | ☐ 200 mg Pre-filled Syringe | ☐ **INITIAL:** Inject 400 mg SQ (two 200 mg injections) SQ at week 0 (Quantity: 2)<br>☐ **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 at week 0 (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2) | |
| | ☐ 300 mg Pen | ☐ Inject 300 mg SQ every **other** week (Quantity: 2) *****Dosing intended for chronic rhinosinusitis with nasal polyposis (CRSwNP)***** | |
| **Fasenra®** | ☐ 30 mg Pre-filled Syringe<br>☐ 30 mg Autoinjector Pen | ☐ **INITIAL:** Inject 30 mg SQ at week 0, week 4, and week 8 (Quantity: 3)<br>☐ **MAINTENANCE:** Inject 30 mg SQ every 8 weeks thereafter (Quantity: 1) | |
| **Nucala®** | ☐ 100 mg Vial<br>☐ 100 mg Autoinjector | **ADULT:**<br>☐ Inject 100 mg SQ once every 4 weeks (Quantity: 1)<br>**ADOLESCENT (ages 12 and older):**<br>☐ Inject 100 mg SQ once every 4 weeks (Quantity: 1) | |
| | ☐ 100 mg Vial | **PEDIATRIC (ages 6 to 11):**<br>☐ Inject 40 mg SQ once every 4 weeks (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: | Therapy Contraindications: |
|---|---|---|---|
| ☐ **Short-acting beta-agonist (SABA):** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Inhaled corticosteroids with long-acting beta-agonist (ICS/LABA) combination therapy:** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Inhaled corticosteroids (without LABA):** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Long-acting muscarinic antagonist (LAMA):** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Leukotriene receptor antagonist (LTRA):** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Oral/injectable corticosteroids:** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Intra-nasal corticosteroids:** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Topical corticosteroids:** ____________________ | ☐ (______________) | ☐ | ____________________ |
| ☐ **Other controller (specify):** ____________________ | ☐ (______________) | ☐ | ____________________ |

IgE Level: ____________________ Date: _____/_____/_______
Number of severe exacerbations past 12 months: ____________________
Eosinophil levels: ___________cells/mcL Date: _____/_____/_______
☐ Patient has moderate to severe asthma that requires add-on maintenance treatment
☐ Patient has had prior sinus surgery Date: _____/_____/_______
☐ Patient is not a candidate for surgery Rationale: ____________________________

**Date of Diagnosis:** _____/_____/_______ **Allergies:** ________________________________________

| | | |
|---|---|---|
| ☐ D86.9 Sarcoidosis, unspecified | ☐ J33.0 Polyp of Nasal Cavity | ☐ J33.9 Nasal Polyp, unspecified |
| ☐ 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

## PRESCRIBER SIGNATURE

**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.

**Prescriber**: **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.