Faxed prescriptions will only be accepted from a prescriber. 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

Basal Cell Carcinoma Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 855-662-6779

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	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		**Directions & Quantity**	**Refills**
Erivedge®	☐ 150 mg Capsules	☐ Take 150 mg once daily by mouth (Quantity: 28)	
Odomzo®	☐ 200 mg Capsules	☐ Take 200 mg once daily by mouth on an empty stomach, at least 1 hour before or 2 hours after a meal (Quantity: 30)	

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:**
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

Erivedge®

Please specify patient as: ☐locally advanced disease ☐metastatic disease

☐ Patient has basal cell carcinoma that has recurred following surgery

☐ Patient has basal cell carcinoma and is *not* a candidate for surgery and *not* a candidate for radiation

Odomzo®

☐ Patient has locally advanced basal cell carcinoma that has recurred following surgery

☐ Patient has locally advanced basal cell carcinoma and is *not* a candidate for surgery and *not* a candidate for radiation

Date of Diagnosis: _____/_____/_____

☐ **C44.91** Basal Cell Carcinoma, unspecified ☐ **C44.**_____ _____

☐ **Other:** _____

Allergies:

Additional Clinical Information:

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