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

Melanoma & Basal Cell Carcinoma Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 855-662-6779

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		Directions & Quantity	Refills
Mekinist®	☐ 2 mg Tablets ☐ 0.5 mg Tablets	☐ Take 2 mg once daily by mouth on an empty stomach, at least 1 hour before or 2 hours after a meal (Quantity: ____)	
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)	
Tafinlar®	☐ 50 mg Capsules ☐ 75 mg Capsules	☐ Take 150 mg twice daily (every 12 hours) by mouth on an empty stomach, at least 1 hour before or 2 hours after a meal (Quantity: ____)	

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

Odomzo®

- ☐ Patient has locally advanced disease that has recurred following surgery
- ☐ Patient has locally advanced disease has recurred following radiation
- ☐ Patient has locally advanced disease and is not a candidate for surgery *or* radiation

Mekinist® and/or Tafinlar®

- ☐ Patient has metastatic disease
- ☐ Patient has unresectable disease
- ☐ Positive for BRAF V600E or V600K mutation as detected by an FDA-approved test **(please attach documentation)**

Allergies:

Date of Diagnosis: _____/_____/_____

- ☐ **C43.9** Malignant Melanoma of Skin, unspecified
- ☐ **C44.91** Basal Cell Carcinoma, unspecified
- ☐ **Other:** _____
- ☐ **C43.**___ _____
- ☐ **C44.**___ _____

Additional Clinical Information:

PATIENT CONSENT TO MANUFACTURER SUPPORT PROGRAMS

To Patient: By signing this form and utilizing our services, you are also authorizing Senderra to gain access and enroll you in any available manufacturer supported patient programs on your behalf.

Patient Signature:	**Date**: _____/_____/_____

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