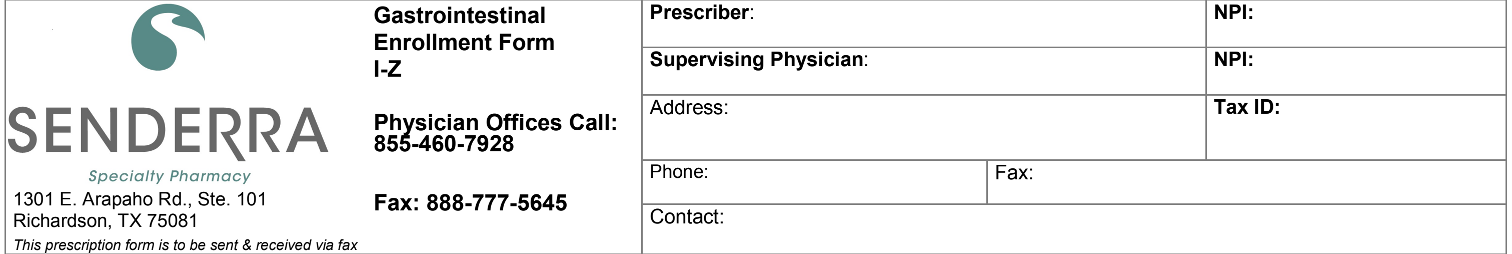
Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



SENDERRA Specialty Pharmacy

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

This prescription form is to be sent & received via fax

Gastrointestinal Enrollment Form I-Z

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	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		Directions & Quantity	Refills
Remicade®	☐ Vials	☐ **INITIAL:** Infuse ________mg IV at week 0, 2, and 6 (Quantity: ____) ☐ **MAINTENANCE:** Infuse ________mg IV every 8 weeks (Quantity: ____)	
Simponi®	☐ 100 mg SmartJect® Pen ☐ 100 mg Pre-filled Syringe	☐ **INITIAL:** Inject 200 mg SQ at week 0, then 100 mg at week 2 (Quantity: 3) ☐ **MAINTENANCE:** Inject 100 mg SQ every 4 weeks (Quantity: 1)	
Stelara®	☐ 130 mg/26mL Vials ☐ Pre-filled Syringe **Weight Required:**____________	☐ **INITIAL INTRAVENOUS DOSAGE:** A single intravenous infusion using weight-based dosing: Up to 55kg=260 mg (2 vials), >55kg to 85kg=390 mg (3 vials), >85kg=520 mg (4 vials) ☐ **MAINTENANCE:** Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (1 syringe)	
Xeljanz®	10 mg Tablets	☐ **INITIAL:** Take 10 mg PO twice daily (Quantity: 60 with 1 refill)	
	5 mg Tablets 10 mg Tablets	☐ **MAINTENANCE:** Take 5 mg PO twice daily (Quantity: 60) ☐ **MAINTENANCE:** Take 10 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	22 mg Tablets	☐ **INITIAL:** Take 22 mg PO once daily (Quantity: 30 with 1 refill)	
	11 mg Tablets 22 mg Tablets	☐ **MAINTENANCE:** Take 11 mg PO once daily (Quantity: 30) ☐ **MAINTENANCE:** Take 22 mg PO once daily (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:	Contraindication:
☐ Methotrexate	☐ (__________________)	☐	________________________
☐ Sulfasalazine	☐ (__________________)	☐	________________________
☐ Pentasa	☐ (__________________)	☐	________________________
☐ Entocort	☐ (__________________)	☐	________________________
☐ Cimzia	☐ (__________________)	☐	________________________
☐ Humira	☐ (__________________)	☐	________________________
☐ __________________	☐ (__________________)	☐	________________________
☐ __________________	☐ (__________________)	☐	________________________

☐ K50.00 Crohn's disease of small intestine, without complications
☐ K50.80 Crohn's disease of both intestines, without complications
☐ K51.50 Left-sided Ulcerative Colitis, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ K50.10 Crohn's disease of large intestine, without complications
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.80 Other Ulcerative Colitis, without complications
☐ Other: ____________________________________

Date of Diagnosis: ____/____/________ **Allergies:**____

Active TB is ruled out: ☐Yes ☐No Date: ____/____/________ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/________

☐Patient is steroid dependent

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.