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

Gastrointestinal Enrollment Form A-H

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		Directions & Quantity	Refills
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)	
Entyvio™	☐ Vials	☐ **INITIAL:** Infuse 300 mg IV over 30 minutes at Day 0, 14, and 42 (Quantity: 3) ☐ **MAINTENANCE:** Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1)	
Humira® *Citrate Free*	☐ Adult Crohn's/UC Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ Pediatric Crohn's Starter Kit ☐ Pre-filled Syringe 20 mg	**PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 15, then 20 mg every **other** week starting on day 29 (Quantity: 2) ☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for weight 17 kg/37 lbs to <40 kg/88 lbs***	
	☐ Pediatric Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ***Intended for weight ≥40 kg/88 lbs***	
Humira®	☐ Adult Crohn's/UC Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on day 1, then 80 mg on day 15 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every other week (Quantity: 2)	
	☐ Pediatric Crohn's Starter Kit ☐ Pre-filled Syringe 20 mg	**PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 80 mg SQ day 1, 40 mg day 15, then 20 mg every **other** week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for weight 17 kg/37 lbs to <40 kg/88 lbs***	
	☐ Pediatric Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ day 1, 80 mg day 15, then 40 mg every **other** week starting day 29 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ***Intended for weight ≥40 kg/88 lbs***	

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

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.