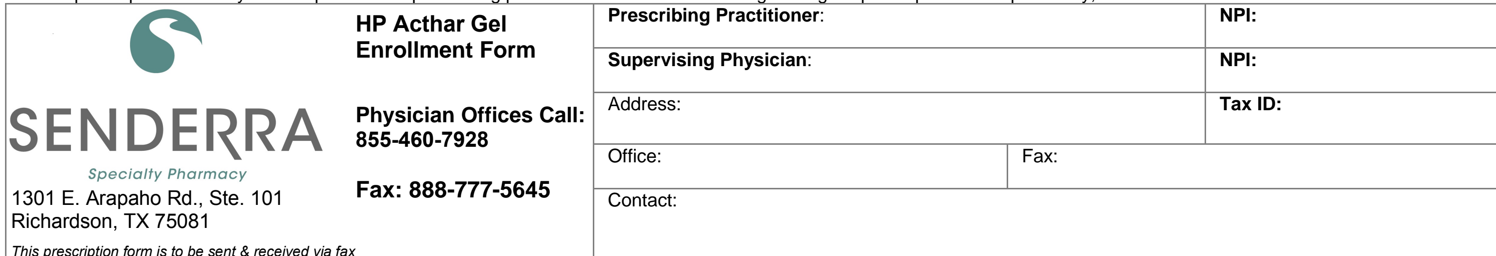
Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



SENDERRA Specialty Pharmacy
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

HP Acthar Gel Enrollment Form

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**
HP Acthar® Gel	☐ 5mL multidose vial	**Dose:** __________ ☐Units ☐ mL	**Route of Administration:** ☐IM ☐ SQ	**Schedule/Frequency:** ____________ ____________	**Quantity of Vials:**	
Supplies	☐ Sharps Container ☐ Syringe ☐ Needles	☐ 1cc syringe ☐ 23 G x 1" ☐ 25 G x 5/8"			**Quantity:** __________ **Quantity:** __________ **Quantity:** __________	

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES & LAB WORK PERTINENT TO THERAPY*****

PREVIOUS THERAPIES:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ ______________________	☐ (__________________)	☐	__________________
☐ ______________________	☐ (__________________)	☐	__________________
☐ ______________________	☐ (__________________)	☐	__________________

☐ **M06.9** Rheumatoid Arthritis, unspecified
☐ **M33.20** Polymyositis, organ involvement unspecified
☐ **M45.9** Ankylosing Spondylitis of unspecified sites in spine
☐ **D86.9** Sarcoidosis, unspecified
☐ Other:________________
☐ **M33.90** Dermatopolymyositis, unspecified, organ involvement unspecified
☐ **M32.10** Systemic lupus erythematosus, organ or system involvement unspecified
☐ **M08.00** Unspecified Juvenile Rheumatoid Arthritis of unspecified site
☐ **L40.50** Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)

☐ **G35** Multiple Sclerosis **Is Acthar to be used to treat an acute exacerbation?** ☐**Yes** ☐ **No (If yes, please provide date of onset: ___/___/______)**
☐ Other:________________

☐ **G40.821** Infantile Spasms, *with* intractable epilepsy
☐ **G40.822** Infantile Spasms *without* intractable epilepsy
Has diagnosis been confirmed by EEG? ☐**Yes** ☐ **No**
☐ Other:________________

☐ **R80.9** Proteinuria (Please indicate etiology):
☐Focal Segmental Glomerular Sclerosis (FSGS)
☐Lupus Nephritis
☐IgA Nephropathy (IgAN)
☐Membranous Nephropathy (MN)
☐ Other:________________

☐**H16.9** Keratitis, unspecified
☐**H46.9** Optic Neuritis, unspecified
☐**H30.009** Chorioretinitis and Focal Retinochoroiditis
☐ Other:________________
☐**H20.9** Iridocyclitis (Uveitis), unspecified
☐**H30.90** Unspecified Chorioretinal inflammation, unspecified eye (Choroiditis)
☐**H16.409** Unspecified Corneal Neovascularization, unspecified eye

Allergies: ______________________ **Date of Diagnosis:** ____/____/______

History of Corticosteroid Use

A corticosteroid was tried with the following response(s):
☐Patient hypersensative or allergic
☐Patient intolerant to corticosteroids
☐Corticosteroid use failed, but same response not expected with HP Acthar Gel
☐ Previous corticosteroids tried were: ☐Oral ☐ IV

A corticosteroid was *not* tried due to the following response(s):
☐Corticosteroid use is contraindicated for this patient
☐Patient has known intolerance to corticosteroids
☐Intravenous access is not possible for this patient
☐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

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

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