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 and received via fax

Hemophilia 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:** _____

Factor I (Recombinant)	☐ RiaSTAP®
Factor VIIa (Recombinant)	☐ NovoSeven® RT
Factor VIII (Recombinant)	☐ Advate® ☐ Adynovate® ☐ Afstyla® ☐ Eloctate™ ☐ Hexilate® FS ☐ Kogenate® FS ☐ Kovaltry® ☐ NovoEight® ☐ Nuwiq® ☐ Obizur® ☐ Recombinate® ☐ Xyntha®
Factor VIII (Human)	☐ Hemofil® M ☐ Monarc-M™
Factor VIII (Human) + VWF	☐ Alphanate® SD ☐ Humate-P® ☐ Koāte® DVI ☐ Wilate®
Factor IX (Recombinant)	☐ Alprolix® ☐ Benefix® RT ☐ Idelvion® ☐ Ixinity® ☐ Rixubis®
Factor IX (Human)	☐ AlphaNine® SD ☐ Mononine® ☐ Proplex T
Factor X Activator (Human/Recombinant)	☐ Hemlibra®
Factor X (Human)	☐ Coagadex®
Factor XIII (Human)	☐ Corifact®
Factor XIII (Recombinant)	☐ Tretten®
Von Willebrand Factor (Recombinant)	☐ Vonvendi®
Anti-Inhibitor (Factor)	☐ Feiba®
Pro-Thrombin Complex (Human)	☐ Bebulin® VH ☐ Profilnine® SD

Therapy Regimen for Factor or Inhibitor Products			
	☐ Prophylaxis_____/week	☐ Breakthrough Bleed	☐ Immune Tolerance
	☐ Target Dose: _____IU/kg	☐ Minor: _____IU ± ____%	☐ Target Dose: _____IU/kg
	☐ Dose: _____IU ± ____%	☐ Moderate: _____IU ± ____%	☐ Dose: _____IU ± ____%
	(Assay Variation)	☐ Major: _____IU ± ____%	(Assay Variation)
	# of Doses:_____ Refills:_____	# of Doses:_____ Refills:_____	# of Doses:_____ Refills:_____

Flushing Protocol	☐ Sodium Chloride 0.9% 5-10 mL pre and post medications ☐ Heparin_____ Units/mL _____mL as needed
Ancillary Supplies	☐ As needed for proper administration and proper disposal of medication and infusion supplies
Skilled Nursing Visits	☐ As needed for IV access, administration, and proper clinical monitoring

All nursing services requirements to be completed per pharmacy protocol

Other Medications		
	☐ Amicar®	Directions:_____Qty:_____ Refills: _____
	☐ Lysteda®	Directions:_____Qty:_____ Refills: _____
	☐ Stimate®	Directions:_____Qty:_____ Refills: _____
	☐ _____	Directions:_____Qty:_____ Refills: _____

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

Circulating Factor:_____% **Target Joints:** ☐ No ☐ Yes _____ **Severity:** ☐ Severe (<1%) ☐ Moderate (1-5%) ☐ Mild (>5%)

Inhibitor Activity: ☐ None ☐ Historical ☐ Current _____BU/mL **Access:** ☐ Peripheral ☐ PICC ☐ Implanted Port ☐ Other:_____

Protocol: ☐ Pre-surgical ☐ Prophylaxis ☐ Immune Tolerance ☐ On-demand **Start date:** ____/____/_____ **End date:** _____/____/_____

Diagnosis Date: ____/____/_____ **Allergies:** _____

☐ **D66** Type A- Factor VIII Deficiency
☐ **D67** Type B- Factor IX Deficiency
☐ **D68.1** Type C- Factor XI Deficiency
☐ **D68.2** Hereditary deficiency of other clotting factors
☐ **D68.32** Hemorrhagic disorder due to extrinsic circulating anticoagulants
☐ **D68.4** Acquired coagulation factor deficiency
☐ **D68.0.** Von Willebrand Disease (Type: ☐ 1 ☐ 2 ☐ 3)
☐ **Other:** _____

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