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*

**Intravenous Immune Globulin 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:**_____

| Prescription | Drug | Dose, Directions, & Quantity | Refills |
|---|---|---|---|
| **Immune Globulin Products** | ☐ Flebogamma® 5%<br>☐ Flebogamma® 10% | | |
| | ☐ Gammaked 10%<br>☐ Gammagard Liquid® 10%<br>☐ Gammaplex® 5%<br>☐ Gammaplex® 10%<br>☐ Gammagard® S/D<br>☐ Gamunex-C® 10% | | |
| | ☐ Octagam® 5%<br>☐ Octagam® 10% | | |
| | ☐ Privigen® 10% | | |
| **Other Medications** | ☐ Acetaminophen | | |
| | ☐ Diphenhydramine | | |
| | ☐ Heparin | | |
| | ☐ Sodium Chloride 0.9% 5-10mL | | |
| | ☐ Solu-Cortef® | | |
| | ☐ Solu-Medrol® | | |

## 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: |
|---|---|---|---|
| ☐ _____ | ☐(_____) | ☐ | _____ |
| ☐ _____ | ☐(_____) | ☐ | _____ |
| ☐ _____ | ☐(_____) | ☐ | _____ |

**Diagnosis (ICD-10):** _____ **Date of Diagnosis:** _____/_____/_____

**IgA Deficiency:** ☐ Yes ☐ No **IgA level:** _____mg/dL **Date:**____/____/_____

**IgG trough:** _____mg/dL **Date:**____/____/_____

**Access:** ☐ Peripheral ☐ PICC ☐ Implant Port ☐ Broviac®/Hickman®

**Allergies:**

Additional Clinical Information:

## 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.