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

Juvenile Idiopathic Arthritis (JIA) Enrollment Form

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

☐ **New** ☐ **Refill** | **Ship by:** ____/____/_____ | **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug		Directions	Quantity	Refills
Actemra®	☐ Vials	**INTRAVENOUS (IV):** ☐ **PJIA –** Infuse 10 mg/kg every 4 weeks via IV **(< 30 kg)** ☐ **PJIA –** Infuse 8 mg/kg every 4 weeks via IV **(≥ 30 kg)** ***WEIGHT REQUIRED*** _____ ☐ **SJIA –** Infuse 12 mg/kg every 2 weeks via IV **(< 30 kg)** ☐ **SJIA –** Infuse 8 mg/kg every 2 weeks via IV **(≥ 30 kg)**		
	☐ Pre-filled Syringe ☐ ACTPen™	**SUBCUTANEOUS (SQ):** ☐ **PJIA –** Inject 162 mg SQ once every 3 weeks **(< 30 kg)** ☐ **PJIA –** Inject 162 mg SQ once every 2 weeks **(≥ 30 kg)** ***WEIGHT REQUIRED*** _____ ☐ **SJIA –** Inject 162 mg SQ once every 2 weeks **(< 30 kg)** ☐ **SJIA –** Inject 162 mg SQ once weekly **(≥ 30 kg)**	**1** **2** **2** **4**	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	☐ Inject ___ mg (0.8mg/kg x ___kg SQ every week) **(≤63 kg)** ***WEIGHT REQUIRED*** _____ ☐ Inject 50 mg SQ every week **(>63 kg)**	____ x 25 mg/mL **4**	
HP Acthar® Gel	☐ 5mL multidose vial	**Dose:** _____ ☐ Units ☐ mL **Route of Administration:** ☐ IM ☐ SQ **Schedule/Frequency:** _____ _____	**Quantity of Vials:**	
Humira® ***Citrate Free***	☐ Pre-filled Syringe ☐ Pen	☐ Inject 10 mg SQ every **other** week **(10 kg to <15 kg)** ☐ Inject 20 mg SQ every **other** week **(15 kg to <30 kg)** ***WEIGHT REQUIRED*** _____ ☐ Inject 40 mg SQ every **other** week **(≥ 30 kg)**		
Humira®	☐ Vials ☐ Pre-filled Syringe ☐ Pen	☐ Inject 10 mg SQ every **other** week **(10 kg to <15 kg)** ☐ Inject 20 mg SQ every **other** week **(15 kg to <30 kg)** ***WEIGHT REQUIRED*** _____ ☐ Inject 40 mg SQ every **other** week **(≥ 30 kg)**		
Orencia®	☐ Vials **WEIGHT REQUIRED:** _____	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV on week 0, 2, and 4 ☐ **MAINTENANCE:** Infuse _____ mg via IV every 4 weeks ***WEIGHT BASED GUIDELINES:*** **(<75 kg: 10 mg/kg)** **(75 kg-100 kg: 750 mg)** **(≥100 kg: 1000 mg)**	**QS 3 doses** **QS: 1 dose**	
	☐ Pre-filled Syringe ☐ ClickJect ™	**SUBCUTANEOUS (SQ):** ☐ Inject 50 mg SQ once weekly **(10 kg to less than 25 kg)** ☐ Inject 87.5 mg SQ once weekly **(25 kg to less than 50 kg)** ***WEIGHT REQUIRED*** _____ ☐ Inject 125 mg SQ once weekly **(≥50 kg)**	**4**	

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	☐ (_____)	☐	_____
☐ Meloxicam	☐ (_____)	☐	_____
☐ Naproxen/Aleve	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Date of Diagnosis: ____/____/_____ Allergies: _____

☐ M08.00 Unspecified Juvenile Idiopathic Arthritis of Unspecified Site ☐ Other: _____

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

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 Rx 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.