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

Miscellaneous Therapy 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
Adcirca®*	☐ 20 mg Tablet		
Aldurazyme®*	☐ 2.9 mg/5 mL Vial		
Botox®*	☐ 100 unit Vial ☐ 200 unit Vial		
Cerezyme®*	☐ 200 unit Vial ☐ 400 unit Vial		
Dysport®*	☐ 300 unit Vial ☐ 500 unit Vial		
Elaprase®*	☐ 6 mg/3 mL Vial		
Epoprostenol Sodium*	☐ 0.5 mg Vial ☐ 1.5 mg Vial		
Fabrazyme®*	☐ 5 mg Vial ☐ 35 mg Vial		
Lucentis®*	☐ 10 mg/mL Pre-filled Syringe ☐ 6 mg/mL Pre-filled Syringe ☐ 10 mg/mL Vial ☐ 6 mg/mL Vial		
Makena®*	☐ 275 mg/1.1 mL Auto-injector ☐ 250 mg Vial ☐ 1250 mg/5 mL Vial		
Myobloc®*	☐ 2,500 unit/0.5 mL Vial ☐ 5,000 unit/1 mL Vial ☐ 10,000 unit/2 mL Vial		
Revatio®* (sildenafil)	☐ 10 mg/mL oral suspension ☐ 20 mg Tablet ☐ 10 mg/12.5 mL Vial		
Soliris®*	☐ 300 mg/30 mL Vial		
Vpriv®*	☐ 400 unit Vial		
Xiaflex®*	☐ 0.9 mg Vial ☐ 0.9 mg Vial Dual Pack		

**Senderra will dispense upon prescriber request*

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**: ____/____/_____ **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