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

Miscellaneous Immunology 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:** __________________

*****REQUIRED*** Patient Weight:________**

Drug		**Directions & Quantity**	**Refills**
Infusion Supplies	☐ 100 mL NS IV bag ☐ 250 mL NS IV bag		
Actemra®	☐ 80 mg Vial ☐ 200 mg Vial ☐ 400 mg Vial	☐ Infuse _____ mg **OR** 8 mg/kg via IV over 1 hour (Quantity: q.s. 1 dose) ☐ Infuse _____ mg **OR** 12 mg/kg via IV over 1 hour (Quantity: q.s. 1 dose)	
Actimmune®	☐ 100 mcg/0.5mL Vial	☐ Inject 50 mcg/m² SQ 3 times per week (**if BSA is greater than 0.5 m²**) (Quantity: 12) ☐ Inject _____ mcg **OR** 1.5mcg/kg/ dose SQ 3 times per week (**if BSA is ≤ 0.5 m²**) (Quantity: q.s. 3 doses)	
Benlysta®	☐ 120 mg/5 mL Vial ☐ 400 mg/20 mL Vial	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____mg or 10 mg/kg via IV over 1 hour every 2 weeks, for 3 doses (Quantity: 3 doses) ☐ **MAINTENANCE:** Infuse _____ mg OR 10 mg/kg via IV over 1 hour every 4 weeks (Quantity: 1 dose)	
	☐ 200 mg Autoinjector ☐ 200 mg Pre-filled syringe	**SUBCUTANEOUS (SQ):** ☐ Inject 200 mg SQ every week (Quantity: 4)	
Nucala®	☐ 100 mg Vial	☐ Inject 300 mg SQ once every 4 weeks (Quantity: 3)	
☐**Remicade®** ☐**Inflectra®**	☐ 100 mg Vial	☐ **INITIAL:** Infuse _____ mg **OR** _____ mg/kg via IV at weeks 0, 2, and 6 (Quantity: q.s. 3 doses) ☐ **MAINTENANCE:** Infuse _____ mg **OR** _____ mg/kg via IV every ______ weeks thereafter (Quantity: q.s. 1 dose)	
Rituxan®	☐ 100 mg/10 mL Vial ☐ 500 mg/50 mL Vial	☐ Infuse _____ mg on ☐Day 1 and Day 15 ☐Once a week for 4 weeks ☐ Other:________________________ 100 mg Vial Quantity: _____ 500 mg Vial Quantity: _____	

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	☐ (__________________)	☐	________________________________
☐ Plaquenil	☐ (__________________)	☐	________________________________
☐ Meloxicam	☐ (__________________)	☐	________________________________
☐ Naproxen / Aleve	☐ (__________________)	☐	________________________________
☐ Enbrel	☐ (__________________)	☐	________________________________
☐ Humira	☐ (__________________)	☐	________________________________
☐ Cimzia	☐ (__________________)	☐	________________________________
☐ _________________	☐ (__________________)	☐	________________________________

☐ C71 Functional disorders of polymorphonuclear neutrophils (CGD)
☐ K51.90 Ulcerative colitis, unspecified, without complications
☐ L40.0 Psoriasis Vulgaris
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, unspecified
☐ M30.1 Eosinophillic granulomatosis with polyangiitis (EGPA)
☐ M31.7 Microscopic polyangiitis
☐ M45.9 Ankylosing Spondylitis, unspecified
☐ Cytokine Release Syndrome (please provide ICD-10): _______________
☐ K50.90 Crohn's disease, unspecified, without complications
☐ L10.0 Pemphigus Vulgaris
☐ L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
☐ M06.9 Rheumatoid Arthritis, unspecified
☐ M31.30 Granulomatosis with polyangiitis (Wegener's)
☐ M32.10 Systemic Lupus Erythematosus, organ or system involvement Unspecified
☐ Q78.2 Osteopetrosis
☐ Other: ____

Date of Diagnosis: _____/______/__________ **Allergies:**____

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

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.