



SENDERRA

Specialty Pharmacy
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

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:		

This prescription form is to be sent & received via fax

PATIENT INFORMATION

Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: / /	SS#: - -
Street:	City:	State:	ZIP:
Tel:	Alt. Tel:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: Ht.:

PRESCRIPTION

Has the patient received a loading dose/starter kit? Yes Start Date: / / No SHIP TO: Patient's Home Doctor's Office Other: _____
 REQUIRED Patient Weight: _____

Drug	Directions & Quantity	Refills
Infusion Supplies <input type="checkbox"/> 100 mL NS IV bag <input type="checkbox"/> 250 mL NS IV bag		
Actemra® <input type="checkbox"/> 80 mg Vial <input type="checkbox"/> 200 mg Vial <input type="checkbox"/> 400 mg Vial	<input type="checkbox"/> Infuse ____ mg OR 8 mg/kg via IV over 1 hour (Quantity: q.s. 1 dose) <input type="checkbox"/> Infuse ____ mg OR 12 mg/kg via IV over 1 hour (Quantity: q.s. 1 dose)	
Actimmune® <input type="checkbox"/> 100 mcg/0.5mL Vial	<input type="checkbox"/> Inject 50 mcg/m ² SQ 3 times per week (if BSA is greater than 0.5 m ²) (Quantity: 12) <input type="checkbox"/> Inject ____ mcg OR 1.5mcg/kg/ dose SQ 3 times per week (if BSA is ≤ 0.5 m ²) (Quantity: q.s. 3 doses)	
Benlysta® <input type="checkbox"/> 120 mg/5 mL Vial <input type="checkbox"/> 400 mg/20 mL Vial <input type="checkbox"/> 200 mg Autoinjector <input type="checkbox"/> 200 mg Pre-filled syringe	INTRAVENOUS (IV): <input type="checkbox"/> INITIAL: Infuse ____mg or 10 mg/kg via IV over 1 hour every 2 weeks, for 3 doses (Quantity: q.s. 3 doses) <input type="checkbox"/> MAINTENANCE: Infuse ____ mg OR 10 mg/kg via IV over 1 hour every 4 weeks (Quantity: q.s. 1 dose) SUBCUTANEOUS (SQ): <input type="checkbox"/> Inject 200 mg SQ every week (Quantity: 4)	
Nucala® <input type="checkbox"/> 100 mg Vial <input type="checkbox"/> 100 mg Autoinjector	<input type="checkbox"/> Inject 300 mg SQ every 4 weeks (Quantity: 3)	
<input type="checkbox"/> Remicade® <input type="checkbox"/> Inflectra® <input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> INITIAL: Infuse ____ mg OR ____ mg/kg via IV at weeks 0, 2, and 6 (Quantity: q.s. 3 doses) <input type="checkbox"/> MAINTENANCE: Infuse ____ mg OR ____ mg/kg via IV every ____ weeks thereafter (Quantity: q.s. 1 dose)	
<input type="checkbox"/> Rituxan® <input type="checkbox"/> Ruxience™ <input type="checkbox"/> 100 mg/10 mL Vial <input type="checkbox"/> 500 mg/50 mL Vial	<input type="checkbox"/> Infuse ____ mg on <input type="checkbox"/> Day 1 and Day 15 <input type="checkbox"/> Once a week for 4 weeks <input type="checkbox"/> 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:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Plaquenil	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Meloxicam	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Naproxen / Aleve	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____

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