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	☐ 250 ml NS IV bag		
Actemra®	☐ 80 mg Vial ☐ 200 mg Vial ☐ 400 mg Vial	☐ Infuse _____ mg **OR** 4 mg/kg via IV over 1 hour every 4 weeks (Quantity: q.s. 1 dose) ☐ Infuse _____ mg **OR** 8 mg/kg via IV over 1 hour every 4 weeks (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 ☐ 200 mg Autoinjector ☐ 200 mg Pre-filled syringe	**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) **SUBCUTANEOUS (SQ):** ☐ Inject 200 mg SQ every week (Quantity: 4)	
Cimzia®	☐ 200 mg Vial	☐ **INITIAL:** Inject 400 mg SQ on day 0, day 14, and day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Orencia®	☐ 250 mg Vial	☐ **INITIAL:** Infuse _____ mg via IV over 1 hour on week 0, 2, and 4(Quantity: q.s. 3 doses) ☐ **MAINTENANCE:** Infuse _____ mg via IV over 1 hour every 4 weeks (Quantity: q.s. 1 dose)	
☐ **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: 1)	
Rituxan®	☐ 500 mg/50 mL Vial	☐ Infuse 1000 mg via IV on week 0 and week 2, repeating every _____ months thereafter (Quantity: 2)	
Simponi® Aria™	☐ 50 mg Vial	☐ **INITIAL:** Infuse 2 mg/kg via IV over 30 minutes at weeks 0 and 4 (Quantity: 2) ☐ **MAINTENANCE:** Infuse 2 mg/kg via IV over 30 minutes every 8 weeks thereafter (Quantity: 1)	

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	☐ (_____)	☐	_____
☐ Tramadol	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ C71 Functional disorders of polymorphonuclear neutrophils (CGD)
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M31.6 Other Giant Cell Arteritis
☐ M45.9 Ankylosing Spondylitis, Unspecified
☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
☐ K50.90 Crohn's disease, Unspecified, without complications
☐ Other: _____

☐ Q78.2 Osteopetrosis
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis)
☐ M32.10 Systemic Lupus Erythematosus, organ or system involvement Unspecified

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