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

Rheumatology Enrollment Form A - H

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
Actemra®	☐ ACTPen™ ☐ Pre-filled Syringe ☐ Vials	☐ **IV:** Infuse _____ mg **OR** _____ mg/kg via IV every 4 weeks (Quantity: ___) ☐ **SQ:** Inject 162 mg SQ every **other** week (Quantity: 2) ☐ **SQ:** Inject 162 mg SQ every week (Quantity: 4)		
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at 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)		
Cosentyx™	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10)	☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Cosentyx™ Covered Until You're Covered	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10)	☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	☐ Inject 50 mg SQ every week (Quantity: 4) ☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8)		
Humira® ***Citrate Free***	☐ Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ weekly (Quantity: 4)		
Humira®	☐ Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 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	☐ (_____)	☐	_____
☐ Plaquenil	☐ (_____)	☐	_____
☐ Naproxen / Aleve	☐ (_____)	☐	_____
☐ Tramadol	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ H20.9 Unspecified Iridocyclitis
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M31.6 Other Giant Cell Arteritis
☐ M45.9 Ankylosing Spondylitis, Unspecified
☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
☐ H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites
☐ M05.79 Rheumatoid Arthritis with rheumatoid factor of mult. sites w/o organ or system involvement
☐ 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