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 I - Z

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
Kevzara®	☐ Pen ☐150 mg ☐ 200 mg ☐ Pre-filled Syringe ☐150 mg ☐ 200 mg	☐ Inject 150 mg SQ every 2 weeks (Quantity: 2) ☐ Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Olumiant®	2 mg Tablets	☐ Take 2 mg PO once daily (Quantity: 30)	
Orencia®	☐ Vials ☐ Pre-filled Syringe ☐ ClickJect™	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV on week 0, 2, and 4(Quantity: ___) ☐ **MAINTENANCE:** Infuse _____ mg via IV every 4 weeks (Quantity: ___) **SUBCUTANEOUS (SQ):** ☐ Inject 125mg SQ once weekly (Quantity: 4)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month (Quantity: 1)	
Xeljanz®	5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)	

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	☐(_____)	☐	_____
☐ Sulfasalazine	☐(_____)	☐	_____
☐ Meloxicam	☐(_____)	☐	_____
☐ Naproxen / Aleve	☐(_____)	☐	_____
☐ Tramadol	☐(_____)	☐	_____
☐ Enbrel	☐(_____)	☐	_____
☐ Humira	☐(_____)	☐	_____
☐ Cimzia	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

☐ 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
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M45.9 Ankylosing Spondylitis, Unspecified
☐ 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