Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.

SENDERRA
Specialty Pharmacy
3712 E. Plano Parkway, Ste. 200 Plano, TX 75074
This prescription form is to be sent & received via fax

Asthma/Respiratory Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ 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:** _____

Drug	Strength	Directions & Quantity	Refills
Actemra®	☐ 162 mg ACTPen® ☐ 162 mg Pre-filled Syringe	☐ Inject 162 mg SQ every week (Quantity: 4)	
Acthar® Gel	☐ 5 mL multi-dose vial	**Dose:** _____ ☐ Units ☐ mL; **Route of Administration:** ☐ IM ☐ SQ; **Schedule/Frequency:** _____ _____; **Quantity of Vials:**	
	☐ 80 units/mL SelfJect™ ☐ 40 units/0.5mL SelfJect™	**Route of Administration:** ■ SQ; **Schedule/Frequency:** _____ _____; **Quantity of Injectors:**	
Dupixent®	☐ 200 mg Pre-filled Syringe ☐ 200 mg Pen	☐ **INITIAL:** Inject 400 mg SQ (two 200 mg injections) at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week starting at day 15 (Quantity: 2)	
	☐ 300 mg Pre-filled Syringe ☐ 300 mg Pen	☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2)	
		☐ Inject 300 mg SQ every **other** week (Quantity: 2) ***Dosing intended for chronic rhinosinusitis with nasal polyposis (CRSwNP)***	
Nucala®	☐ 100 mg Vial ☐ 100 mg Autoinjector	☐ Inject 100 mg SQ once every 4 weeks (Quantity: 1)	
Purified Cortrophin® Gel	☐ 1 mL multi-dose vial ☐ 5 mL multi-dose vial	**Dose:** _____ ☐ Units ☐ mL; **Route of Administration:** ☐ IM ☐ SQ; **Schedule/Frequency:** _____ _____; **Quantity of Vials:**	

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:	Therapy Contraindications:
☐ **Short-acting beta-agonist (SABA):**_____	☐ (_____)	☐	_____
☐ **Inhaled corticosteroids with long-acting beta-agonist (ICS/LABA) combination therapy:**_____	☐ (_____)	☐	_____
☐ **Inhaled corticosteroids (without LABA):**_____	☐ (_____)	☐	_____
☐ **Long-acting muscarinic antagonist (LAMA):**_____	☐ (_____)	☐	_____
☐ **Leukotriene receptor antagonist (LTRA):**_____	☐ (_____)	☐	_____
☐ **Oral/injectable corticosteroids:**_____	☐ (_____)	☐	_____
☐ **Other controller (specify):**_____	☐ (_____)	☐	_____

IgE Level: _____ Date: ____/____/_____

Eosinophil levels: _____cells/mcL Date: ____/____/_____

☐ Patient has had prior sinus surgery Date: ____/____/_____

Number of severe exacerbations past 12 months: _____

☐ Patient has moderate to severe asthma that requires add-on maintenance treatment

☐ Patient is not a candidate for surgery Rationale: _____

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

☐ D86.9 Sarcoidosis, unspecified
☐ J32.9 Chronic sinusitis, unspecified
☐ J33.0 Polyp of Nasal Cavity
☐ J33.9 Nasal Polyp, unspecified
☐ J45.40 Moderate Persistent Asthma, uncomplicated
☐ J45.41 Moderate Persistent Asthma w/ acute exacerbation
☐ J45.50 Severe Persistent Asthma, uncomplicated
☐ J45.51 Severe Persistent Asthma w/ acute exacerbation
☐ M34.81 Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
☐ Other: _____

Additional Clinical Information:

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Senderra to coordinate injection training

PRESCRIBER SIGNATURE

To Prescriber: 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.

Prescriber: **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.