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

Gastrointestinal Enrollment Form A-H

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		Directions & Quantity	Refills
Cimzia®	☐ 200 mg Pre-filled Syringe ☐ 200 mg Vial	☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)	
Dupixent®	☐ 200 mg Pre-filled Syringe ☐ 200 mg Pen*	***WEIGHT REQUIRED*** _____ *** *Dupixent pen indicated for ages 2 and older* ☐ Inject 200 mg SQ every **other** week (Quantity: 2) ***Intended for ages 1 and older with weight 15kg/33 lbs to < 30 kg/66 lbs***	
	☐ 300 mg Pre-filled Syringe ☐ 300 mg Pen*	☐ Inject 300 mg SQ every **other** week (Quantity: 2) ***Intended for ages 1 and older with weight 30kg/88 lbs to < 40 kg/88 lbs*** ☐ Inject 300 mg SQ every week (Quantity: 4) ***Intended for ages 1 and older with weight ≥ 40 kg/88 lbs***	
Entyvio®	☐ 300 mg Vial	☐ **INITIAL:** Infuse 300 mg IV over 30 minutes at Day 0, 14, and 42 (Quantity: 3) ☐ **MAINTENANCE:** Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1)	
Humira® *Citrate Free*	☐ 80 mg/0.8 mL Pen	**ADULT:** ☐ **INITIAL:** Inject 160 mg (2 pens) SQ on day 1 (Quantity: 2)	
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 80 mg SQ on day 15, then 40 mg SQ every **other** week starting day 29 (Quantity: 4)	
	☐ 40 mg/0.4 mL Pre-filled Syringe	**PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 80 mg (two 40 mg injections) SQ on day 1 (Quantity: 2)	
	☐ 20 mg/0.2 mL Pre-filled Syringe	☐ **INDUCTION:** Inject 40 mg (two 20 mg injections) SQ on day 15, then 20 mg every **other** week starting on day 29 (Quantity: 4)	
	☐ 20 mg/0.2 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for weight 17 kg/37 lbs to <40 kg/88 lbs***	
	☐ 80 mg/0.8 mL Pen	☐ **INITIAL:** Inject 160 mg (2 pens) SQ on day 1 (Quantity: 2)	
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 80 mg SQ on day 15, then 40 mg SQ every **other** week starting day 29 (Quantity: 4) ***Intended for weight ≥40 kg/88 lbs***	
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	**PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, 40 mg on day 15 (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week starting on day 29 (Quantity: 2) ***Intended for weight 20 kg/44 lbs to <40 kg/88 lbs***	
	☐ 20 mg/0.2 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 20 mg SQ every week starting on day 29 (Quantity: 4)	
	☐ 80 mg/0.8 mL Pen ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 8, 80 mg on day 15 (Quantity: QS 28 days) ☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week starting on day 29 (Quantity: 2) ***Intended for weight ≥40 kg/88 lbs*** ☐ **MAINTENANCE:** Inject 40 mg SQ every week starting on day 29 (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	☐ (_____)	☐	_____
☐ Pentasa	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ K20.0 Eosinophilic Esophagitis
☐ K50.00 Crohn's disease of small intestine, without complications
☐ K50.80 Crohn's disease of both intestines, without complications
☐ K51.50 Left-sided Ulcerative Colitis, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ K20. ___ _____
☐ K50.10 Crohn's disease of large intestine, without complications
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.80 Other Ulcerative Colitis, without complications
☐ Other: _____

Date of Diagnosis: ____/____/_____ **Allergies:**_____ ☐Patient is steroid dependent

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

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

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