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 T-Z

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
Tremfya®	☐ 200 mg/20 mL Vial	☐ **INITIAL:** Infuse 200 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills) ***Intended for patients with Ulcerative Colitis OR Crohn's disease***	
	☐ CD/UC Pen Induction Pack ☐ 200 mg Pre-filled Syringe	☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ at week 0, 4, and 8 (Quantity: 2 with 2 refills) ***Intended for patients with Ulcerative Colitis OR Crohn's disease***	
	☐ 100 mg Pen ☐ 100 mg One-Press Injector ☐ 100 mg Pre-filled Syringe	☐ **MAINTENANCE:** Inject 100 mg SQ at week 16 and every 8 weeks thereafter (Quantity: 1)	
	☐ 200 mg Pen ☐ 200 mg Pre-filled Syringe	☐ **MAINTENANCE:** Inject 200 mg SQ at week 12 and every 4 weeks thereafter (Quantity: 1)	
Velsipity™	2 mg Tablet	☐ Take 2 mg PO once daily (Quantity: 30) ☐ **All required assessments are completed and the patient is cleared for therapy**	
Xeljanz®	10 mg Tablets	☐ **INITIAL:** Take 10 mg PO twice daily (Quantity: 60 with 1 refill)	
	5 mg Tablets 10 mg Tablets	☐ **MAINTENANCE:** Take 5 mg PO twice daily (Quantity: 60) ☐ **MAINTENANCE:** Take 10 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	22 mg Tablets	☐ **INITIAL:** Take 22 mg PO once daily (Quantity: 30 with 1 refill)	
	11 mg Tablets	☐ **MAINTENANCE:** Take 11 mg PO once daily (Quantity: 30)	
	22 mg Tablets	☐ **MAINTENANCE:** Take 22 mg PO once daily (Quantity: 30)	
Zeposia®	☐ 7-day Starter Pack ☐ 28-day Starter Kit	☐ **INITIAL:** Take as directed per package instructions (Quantity: QS) ☐ **All required assessments are completed and the patient is cleared for therapy**	
	☐ 0.92 mg Capsule	☐ MAINTENANCE: Take 0.92 mg by mouth once daily starting on day 8 and thereafter (Quantity: 30) **For assistance with pre-assessments visit:** https://www.zeposiaportal.com/zeposiaprovider	
Zymfentra®	☐ 120 mg Pre-filled Syringe w/ needle shield ☐ 120 mg Pen	☐ Inject 120mg SQ every 2 weeks (Quantity: 2) ***All patients must complete an IV induction regimen with an infliximab product before starting ZYMFENTRA®***	

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	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Remicade	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ K50.00 Crohn's disease of small intestine, without complications   ☐ K50.10 Crohn's disease of large intestine, without complications
☐ K50.80 Crohn's disease of both intestines, without complications   ☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.80 Other Ulcerative Colitis, without complications   ☐ K51.90 Ulcerative Colitis unspecified, 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