

 <p>SENDERRA Specialty Pharmacy 3712 E. Plano Parkway, Ste. 200 Plano, TX 75074 <i>This prescription form is to be sent & received via fax</i></p>	<p>Gastrointestinal Enrollment Form I-S</p> <p>Physician Offices Call: 855-460-7928</p> <p>Fax: 888-777-5645</p>	<p>Prescriber: _____ NPI: _____</p> <p>Supervising Physician: _____ NPI: _____</p> <p>Address: _____ Tax ID: _____</p> <p>Phone: _____ Fax: _____</p> <p>Contact: _____</p>
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PATIENT INFORMATION

Name: _____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: ____/____/____	SS#: _____
Street: _____	City: _____	State: _____	ZIP: _____
Phone: _____	Alt. Phone: _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

Has the patient received a loading dose/starter kit? <input type="checkbox"/> Yes Start Date: ____/____/____ <input type="checkbox"/> No		SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____	
Drug	Directions & Quantity		Refills
Omvo® <input type="checkbox"/> 300 mg/15 mL Vial <input type="checkbox"/> 200 mg Pen <input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg +100 mg Pen <input type="checkbox"/> 200 mg +100 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Infuse 300 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills) ***Intended for patients with Ulcerative Colitis*** <input type="checkbox"/> INITIAL: Infuse 900 mg via IV at week 0, 4, and 8 (Quantity: 3 with 2 refills) ***Intended for patients with Crohn's disease***		
	<input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ 4 weeks at week 12, then every 4 weeks thereafter (Quantity: 1) ***Intended for patients with Ulcerative Colitis***		
	<input type="checkbox"/> MAINTENANCE: Inject 300 mg (one 200 mg injection, one 100 mg injection) SQ 4 weeks at week 12, then every 4 weeks thereafter (Quantity: 2) ***Intended for patients with Crohn's disease***		
Rinvoq® 45 mg Tablets 15 mg Tablets 30 mg Tablets	<input type="checkbox"/> INITIAL: Take 45 mg PO once daily (Quantity: 28 with 1 refill) ***Intended for patients with Ulcerative Colitis*** <input type="checkbox"/> INITIAL: Take 45 mg PO once daily (Quantity: 28 with 2 refills) ***Intended for patients with Crohn's disease***		
	<input type="checkbox"/> MAINTENANCE: Take 15 mg PO once daily (Quantity: 30)		
	<input type="checkbox"/> MAINTENANCE: Take 30 mg PO once daily (Quantity: 30)		
Simponi® <input type="checkbox"/> 100 mg SmartJect® Pen <input type="checkbox"/> 100 mg Pre-filled Syringe* <input type="checkbox"/> 100 mg Pre-filled Syringe <input type="checkbox"/> 50 mg Pre-filled Syringe	WEIGHT REQUIRED: _____		
	<input type="checkbox"/> INITIAL: Inject 200 mg SQ at week 0 (Quantity: 2) <input type="checkbox"/> INDUCTION: Inject 100 mg SQ at week 2 (Quantity: 1) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 4 weeks (Quantity: 1)		***Intended for adult and pediatric patients ≥ 40 kg (88 lbs)***
	<input type="checkbox"/> INITIAL: Inject 100 mg SQ at week 0 (Quantity: 1) <input type="checkbox"/> INDUCTION: Inject 50 mg SQ at week 2 (Quantity: 1) <input type="checkbox"/> MAINTENANCE: Inject 50 mg SQ every 4 weeks (Quantity: 1)		***Intended for pediatric patients 15kg (33 lbs) to <40 kg (88 lbs)***
Skyrizi® <input type="checkbox"/> 600 mg/10 mL Vial <input type="checkbox"/> 180 mg/1.2 mL Pre-filled cartridge via On-Body Injector <input type="checkbox"/> 360 mg/2.4 mL Pre-filled cartridge via On-Body Injector	<input type="checkbox"/> INITIAL: Infuse 600 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills) ***Intended for patients with Crohn's disease*** <input type="checkbox"/> INITIAL: Infuse 1200 mg via IV at week 0, 4, and 8 (Quantity: 2 with 2 refills) ***Intended for patients with Ulcerative Colitis***		
	<input type="checkbox"/> MAINTENANCE: Inject 180 mg SQ 4 weeks after final initial dose (week 12), then every 8 weeks thereafter (Quantity: 1) <input type="checkbox"/> MAINTENANCE: Inject 360 mg SQ 4 weeks after final initial dose (week 12), then every 8 weeks thereafter (Quantity: 1)		
Stelara® <input type="checkbox"/> 130 mg/26mL Vial <input type="checkbox"/> Pre-filled Syringe	WEIGHT REQUIRED: _____		
	<input type="checkbox"/> INITIAL INTRAVENOUS DOSAGE: A single intravenous infusion using weight-based dosing: Up to 55kg=260 mg (2 vials), >55kg to 85kg=390 mg (3 vials), >85kg=520 mg (4 vials) <input type="checkbox"/> MAINTENANCE: Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (1 syringe)		

*Simponi PFS FDA approved for pediatric use

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:
<input type="checkbox"/> Methotrexate <input type="checkbox"/> Cimzia <input type="checkbox"/> Humira <input type="checkbox"/> _____	<input type="checkbox"/> (_____) _____ <input type="checkbox"/> (_____) _____ <input type="checkbox"/> (_____) _____ <input type="checkbox"/> (_____) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ _____ _____
<input type="checkbox"/> K50.00 Crohn's disease of small intestine, without complications <input type="checkbox"/> K50.80 Crohn's disease of both intestines, without complications <input type="checkbox"/> K51.80 Other Ulcerative Colitis, without complications <input type="checkbox"/> Other: _____		<input type="checkbox"/> K50.10 Crohn's disease of large intestine, without complications <input type="checkbox"/> K50.90 Crohn's disease unspecified, without complications <input type="checkbox"/> K51.90 Ulcerative Colitis unspecified, without complications	
Date of Diagnosis: ____/____/____	Allergies: _____		<input type="checkbox"/> Patient is steroid dependent
Active TB is ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____	Hep B ruled out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> 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

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.