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 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***	
	☐ 200 mg Pen ☐ 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 Crohn's disease***	
	☐ 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

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.