



Gastrointestinal Enrollment Form A-H
Physician Offices Call: 855-460-7928
Fax: 888-777-5645

3712 E. Plano Parkway, Ste. 200
 Plano, TX 75074

This prescription form is to be sent & received via fax

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

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? Yes Start Date: / / No SHIP TO: Patient's Home Doctor's Office Other: _____

Drug	Directions & Quantity	Refills
Cimzia® <input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Vial	<input type="checkbox"/> INITIAL: Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)	
Dupixent® <input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Pen* <input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen*	***WEIGHT REQUIRED*** _____ *Dupixent pen indicated for ages 2 and older* <input type="checkbox"/> 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*** <input type="checkbox"/> 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*** <input type="checkbox"/> Inject 300 mg SQ every week (Quantity: 4) ***Intended for ages 1 and older with weight ≥ 40 kg/88 lbs***	
Entyvio® <input type="checkbox"/> 300 mg Vial <input type="checkbox"/> 108 mg/0.68 mL Pre-filled Syringe	<input type="checkbox"/> INITIAL: Infuse 300 mg IV over 30 minutes at Day 0, 14, and 42 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1) <input type="checkbox"/> Inject 108 mg SQ every other week (Quantity: 2)	
Humira® Citrate Free <input type="checkbox"/> 80 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe <input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe <input type="checkbox"/> 20 mg/0.2 mL Pre-filled Syringe <input type="checkbox"/> 20 mg/0.2 mL Pre-filled Syringe <input type="checkbox"/> 80 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe <input type="checkbox"/> 20 mg/0.2 mL Pre-filled Syringe <input type="checkbox"/> 80 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe	ADULT: <input type="checkbox"/> INITIAL: Inject 160 mg (2 pens) SQ on day 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ on day 15, then 40 mg SQ every other week starting day 29 (Quantity: 4)	
	PEDIATRIC: ***WEIGHT REQUIRED*** _____ <input type="checkbox"/> INITIAL: Inject 80 mg (two 40 mg injections) SQ on day 1 (Quantity: 2)	
	<input type="checkbox"/> INDUCTION: Inject 40 mg (two 20 mg injections) SQ on day 15, then 20 mg every other week starting on day 29 (Quantity: 4)	
	<input type="checkbox"/> MAINTENANCE: Inject 20 mg SQ every other week (Quantity: 2) ***Intended for weight 17 kg/37 lbs to < 40 kg/88 lbs***	
	<input type="checkbox"/> INITIAL: Inject 160 mg (2 pens) SQ on day 1 (Quantity: 2)	
	<input type="checkbox"/> 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***	
	<input type="checkbox"/> PEDIATRIC: ***WEIGHT REQUIRED*** _____ <input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, 40 mg on day 15 (Quantity: 4) ***Intended for weight 20 kg/44 lbs to < 40 kg/88 lbs***	
	<input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week starting on day 29 (Quantity: 2) ***Intended for weight ≥ 40 kg/88 lbs***	
<input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 8, 80 mg on day 15 (Quantity: QS 28 days)		
<input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every other week starting on day 29 (Quantity: 2)		
<input type="checkbox"/> 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:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> ()	<input type="checkbox"/>	_____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> ()	<input type="checkbox"/>	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> ()	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/> ()	<input type="checkbox"/>	_____
<input type="checkbox"/> K20.0 Eosinophilic Esophagitis		<input type="checkbox"/> K20. _____	
<input type="checkbox"/> K50.00 Crohn's disease of small intestine, without complications		<input type="checkbox"/> K50.10 Crohn's disease of large intestine, without complications	
<input type="checkbox"/> K50.80 Crohn's disease of both intestines, without complications		<input type="checkbox"/> K50.90 Crohn's disease unspecified, without complications	
<input type="checkbox"/> K51.50 Left-sided Ulcerative Colitis, without complications		<input type="checkbox"/> K51.80 Other Ulcerative Colitis, without complications	
<input type="checkbox"/> K51.90 Ulcerative Colitis unspecified, without complications		<input type="checkbox"/> Other: _____	
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: / /
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CONFIDENTIALITY NOTICE

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