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
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent & received via fax

Gastrointestinal Enrollment Form I-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
Rinvoq®	45 mg Tablets	☐ **INITIAL:** Take 45 mg PO once daily (Quantity: 28 with 1 refill) ***Intended for patients with Ulcerative Colitis***	
		☐ **INITIAL:** Take 45 mg PO once daily (Quantity: 28 with 2 refills) ***Intended for patients with Crohn's disease***	
	15 mg Tablets	☐ **MAINTENANCE:** Take 15 mg PO once daily (Quantity: 30)	
	30 mg Tablets	☐ **MAINTENANCE:** Take 30 mg PO once daily (Quantity: 30)	
Simponi®	☐ 100 mg SmartJect® Pen	☐ **INITIAL:** Inject 200 mg SQ at week 0, then 100 mg at week 2 (Quantity: 3)	
	☐ 100 mg Pre-filled Syringe	☐ **MAINTENANCE:** Inject 100 mg SQ every 4 weeks (Quantity: 1)	
Skyrizi®	☐ 600 mg/10 mL Vial	☐ **INITIAL:** Infuse 600 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills)	
	☐ 180 mg/1.2 mL Pre-filled cartridge via On-Body Injector	☐ **MAINTENANCE:** Inject 180 mg SQ 4 weeks after final initial dose (week 12), then every 8 weeks thereafter (Quantity: 1)	
	☐ 360 mg/2.4 mL Pre-filled cartridge via On-Body Injector	☐ **MAINTENANCE:** Inject 360 mg SQ 4 weeks after final initial dose (week 12), then every 8 weeks thereafter (Quantity: 1)	
Stelara®	☐ 130 mg/26mL Vial	☐ **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)	
	☐ Pre-filled Syringe **Weight Required:** _____	☐ **MAINTENANCE:** Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (1 syringe)	
Xeljanz®	10 mg Tablets	☐ **INITIAL:** Take 10 mg PO twice daily (Quantity: 60 with 1 refill)	
	5 mg Tablets	☐ **MAINTENANCE:** Take 5 mg PO twice daily (Quantity: 60)	
	10 mg Tablets	☐ **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®	☐ Titration pack	☐ **INITIAL:** Take as directed per package instructions ☐ **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	

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	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ 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:**_____

Active TB is ruled out: ☐Yes ☐No Date: ____/____/_____ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/_____
☐Patient is steroid dependent

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.