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 I-S

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
Omvoh™	☐ 300 mg/15 mL Vial ☐ 100 mg Pen ☐ 100 mg Pre-filled Syringe	☐ **INITIAL:** Infuse 300 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills) ☐ **MAINTENANCE:** Inject 200 mg (two 100 mg injections) SQ 4 weeks after final initial dose (week 12), then every 4 weeks thereafter (Quantity: 2)	
Rinvoq®	45 mg Tablets 15 mg Tablets 30 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*** ☐ **MAINTENANCE:** Take 15 mg PO once daily (Quantity: 30) ☐ **MAINTENANCE:** Take 30 mg PO once daily (Quantity: 30)	
Simponi®	☐ 100 mg SmartJect® Pen ☐ 100 mg Pre-filled Syringe	☐ **INITIAL:** Inject 200 mg SQ at week 0, then 100 mg at week 2 (Quantity: 3) ☐ **MAINTENANCE:** Inject 100 mg SQ every 4 weeks (Quantity: 1)	
Skyrizi®	☐ 600 mg/10 mL Vial ☐ 180 mg/1.2 mL Pre-filled cartridge via On-Body Injector ☐ 360 mg/2.4 mL Pre-filled cartridge via On-Body Injector	☐ **INITIAL:** Infuse 600 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills) ***Intended for patients with Crohn's disease*** ☐ **INITIAL:** Infuse 1200 mg via IV at week 0, 4, and 8 (Quantity: 2 with 2 refills) ***Intended for patients with Ulcerative Colitis*** ☐ **MAINTENANCE:** Inject 180 mg SQ 4 weeks after final initial dose (week 12), then every 8 weeks thereafter (Quantity: 1) ☐ **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 ☐ Pre-filled Syringe **Weight Required:** _____	☐ **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) ☐ **MAINTENANCE:** Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (1 syringe)	

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

☐ 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

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