

 SENDERRA <i>Specialty Pharmacy</i> 3712 E. Plano Parkway, Ste. 200 Plano, TX 75074 <i>This prescription form is to be sent & received via fax</i>	Gastrointestinal Enrollment Form A-H Physician Offices Call: 855-460-7928 Fax: 888-777-5645	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">Prescriber:</td> <td>NPI:</td> </tr> <tr> <td colspan="2">Supervising Physician:</td> <td>NPI:</td> </tr> <tr> <td colspan="2">Address:</td> <td>Tax ID:</td> </tr> <tr> <td>Phone:</td> <td colspan="2">Fax:</td> </tr> <tr> <td colspan="3">Contact:</td> </tr> </table>	Prescriber:		NPI:	Supervising Physician:		NPI:	Address:		Tax ID:	Phone:	Fax:		Contact:		
	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? <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	
Cimzia®	<input type="checkbox"/> 200 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6)			
	<input type="checkbox"/> 200 mg Vial	<input type="checkbox"/> MAINTENANCE: Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)			
Dupixent®	<input type="checkbox"/> 300 mg Pre-filled Syringe	<input type="checkbox"/> Inject 300 mg SQ every week (Quantity: 4) ***WEIGHT REQUIRED***			
	<input type="checkbox"/> 300 mg Pen	***Intended for ages 12 and older with weight ≥ 40 kg/88 lbs***			
Entyvio®	<input type="checkbox"/> 300 mg Vial	<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)			
Humira® Citrate Free	<input type="checkbox"/> 80 mg/0.8 mL Crohn's/UC Starter Kit <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 SQ on day 1, 80 mg on day 15, then 40 mg every other week starting day 29 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)			
	<input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe & 20 mg/0.2 mL Pre-filled Syringe <input type="checkbox"/> 20 mg/0.2 mL Pre-filled Syringe	PEDIATRIC: ***WEIGHT REQUIRED*** <input type="checkbox"/> INITIAL: Inject 80 mg (two 40 mg injections) SQ on day 1, 40 mg (two 20 mg injections) 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"/> 80 mg/0.8 mL Crohn's Starter Kit <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every other week starting day 29 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2) ***Intended for weight ≥40 kg/88 lbs***			
	<input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pre-filled Syringe	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) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week starting on day 29 (Quantity: 2) ***Intended for weight 20 kg/44 lbs to <40 kg/88 lbs***			
	<input type="checkbox"/> 20 mg/0.2 mL Pre-filled Syringe <input type="checkbox"/> 80 mg/0.8 mL Pediatric UC Starter Kit <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"/> INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 8, 80 mg on day 15 (Quantity: 4) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every other week starting on day 29 (Quantity: 2) ***Intended for weight ≥40 kg/88 lbs*** <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"/> Sulfasalazine	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Pentasa	<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"/> _____	<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

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.