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	☐ **INITIAL:** Infuse 300 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills) ***Intended for patients with Ulcerative Colitis***	
		☐ **INITIAL:** Infuse 900 mg via IV at week 0, 4, and 8 (Quantity: 3 with 2 refills) ***Intended for patients with Crohn's disease***	
	☐ 200 mg Pen ☐ 200 mg Pre-filled Syringe	☐ **MAINTENANCE:** Inject 200 mg SQ 4 weeks at week 12, then every 4 weeks thereafter (Quantity: 1) ***Intended for patients with Ulcerative Colitis***	
	☐ 200 mg +100 mg Pen ☐ 200 mg +100 mg Pre-filled Syringe	☐ **MAINTENANCE:** Inject 300 mg (one 200 mg injection, one 100 mg injection) SQ 4 weeks at week 12, then every 4 weeks thereafter (Quantity: 2) ***Intended for patients with Crohn's disease***	
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 30 mg Tablets	☐ **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*	**WEIGHT REQUIRED: _____** ☐ **INITIAL:** Inject 200 mg SQ at week 0 (Quantity: 2) ☐ **INDUCTION:** Inject 100 mg SQ at week 2 (Quantity: 1) ☐ **MAINTENANCE:** Inject 100 mg SQ every 4 weeks (Quantity: 1) ***Intended for adult and pediatric patients ≥ 40 kg (88 lbs)***	
	☐ 100 mg Pre-filled Syringe	☐ **INITIAL:** Inject 100 mg SQ at week 0 (Quantity: 1)	
	☐ 50 mg Pre-filled Syringe	☐ **INDUCTION:** Inject 50mg SQ at week 2 (Quantity: 1) ☐ **MAINTENANCE:** Inject 50 mg SQ every 4 weeks (Quantity: 1) ***Intended for pediatric patients 15kg (33 lbs) to <40 kg (88 lbs)***	
Skyrizi®	☐ 600 mg/10 mL Vial	☐ **INITIAL INTRAVENOUS:** Infuse 1200 mg via IV at week 0, 4, and 8 (Quantity: 2 with 2 refills) ***Intended for patients with Ulcerative Colitis***	
		☐ **INITIAL INTRAVENOUS :** Infuse 600 mg via IV at week 0, 4, and 8 (Quantity: 1 with 2 refills) ***Intended for patients with Crohn's disease***	
	☐ Crohn's Induction Pack (360 mg/2.4mL Pre-filled cartridge via OBI)	☐ **INITIAL SUBCUTANEOUS :** Inject 720 mg SQ at week 0, 2, 4, and 8 (Quantity: 4) ***Intended for patients with Crohn's disease***	
	☐ 180 mg/1.2 mL Pre-filled cartridge via OBI ☐ 360 mg/2.4 mL Pre-filled cartridge via OBI	☐ **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/26 mL Vial **WEIGHT REQUIRED: _____**	☐ **INITIAL ADULT 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)	
		☐ **INITIAL PEDIATRIC INTRAVENOUS DOSAGE:** A single intravenous infusion using weight-based dosing: 10kg to 25kg=10 mg/kg (1 vial), >25kg to 55kg= 260mg (2 vials), >55kg to 85kg=390 mg (3 vials), >85kg=520 mg (4 vials)	
	☐ 45 mg/0.5mL Vial	☐ **MAINTENANCE:** Inject 2.5 mg/kg SQ 8 weeks after initial dose, then every 8 weeks thereafter (Quantity: QS 1 dose) ***Intended for pediatric patients 10 kg (22 lbs) to 35kg (77 lbs)***	
	☐ 90 mg/mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (Quantity: 1) ***Intended for adults & pediatric patients >35kg (77 lbs)***	

**Simponi PFS FDA approved for pediatric use*

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	☐ (_____)	☐	_____
☐ 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

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.