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

Oncology Enrollment Form

Physician Offices Call: 877-513-3107

Fax: 855-662-6779

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

☐ **New** ☐ **Refill** **Ship by: ____/____/_____** **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other: _____**

Drug & Strength		Directions & Quantity	Refills
Abiraterone acetate	☐ 250 mg Tablet ☐ 500 mg Tablet		
Bexarotene* **	☐ 75 mg Capsule ☐ 1% Gel 60 gm		
Capecitabine* **	☐ 150 mg Tablet ☐ 500 mg Tablet		
Dasatinib* **	☐ 20 mg Tablet ☐ 50 mg Tablet ☐ 70 mg Tablet ☐ 80 mg Tablet ☐ 100 mg Tablet ☐ 140 mg Tablet		
Deferasirox* **	☐ 90 mg Tablet ☐ 180 mg Tablet ☐ 360 mg Tablet		
Erlotinib	☐ 25 mg Tablet ☐ 100 mg Tablet ☐ 150 mg Tablet		
Everolimus* **	☐ 5 mg Tablet ☐ 7.5 mg Tablet ☐ 10 mg Tablet		
Fulvestrant	☐ 250 mg/5 mL Pre-filled Syringe		
Imatinib* **	☐ 100 mg Tablet ☐ 400 mg Tablet		
Lapatinib	☐ 250 mg Tablet		
Nilutamide	☐ 150 mg Tablet		
Pazopanib	☐ 200 mg Tablet		
Sorafenib	☐ 200 mg Tablet		
Sunitinib	☐ 12.5 mg Capsule ☐ 25 mg Capsule ☐ 37.5 mg Capsule ☐ 50 mg Capsule		
Temozolomide* **	☐ 5 mg Capsule ☐ 20 mg Capsule ☐ 100 mg Capsule ☐ 140 mg Capsule ☐ 180 mg Capsule ☐ 250 mg Capsule		
Other: _____			

***BSA/Weight Required

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:	Reason(s) for Discontinuation:
☐ _____	☐ _____	☐	_____
☐ _____	☐ _____	☐	_____

Date of Diagnosis: ____/____/_____ **TNM Stage: _____** **Mutation(s) Present: _____**

- ☐ **C____** _____
- ☐ **C18.9** Malignant neoplasm of colon, unspecified
- ☐ **C22.0** Liver cell carcinoma
- ☐ **C34.90** Malignant neoplasm of unspecified part of unspecified bronchus or lung
- ☐ **C49.A___** Gastrointestinal stromal tumor of _____
- ☐ **C50._____** Malignant neoplasm of breast
- ☐ **C61** Malignant neoplasm of prostate
- ☐ **C64.9** Malignant neoplasm of unspecified kidney, except renal pelvis
- ☐ **C73** Malignant neoplasm of thyroid gland
- ☐ **C7A._____** _____
- ☐ **C84.A0** Cutaneous T-cell lymphoma, unspecified, unspecified site
- ☐ **C84.A___** Cutaneous T-cell lymphoma, unspecified, _____
- ☐ **C91.0____** Acute lymphoblastic leukemia (ALL)
- ☐ **C92.1____** Chronic Myeloid Leukemia, BCR/ABL-positive
- ☐ **D56. ___** _____
- ☐ **E83.111** Chronic iron overload due to blood transfusions
- ☐ **Other:** _____

Additional Clinical Information:

PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED

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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