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 A-D

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		**Directions & Quantity**	**Refills**
Abiraterone acetate	☐ 250 mg Tablet	☐ Take 1,000 mg (FOUR 250 mg tablets) PO once daily on an empty stomach (Quantity: 120)	
	☐ 500 mg Tablet	☐ Take 1,000 mg (TWO 500 mg tablets) PO once daily on an empty stomach (Quantity: 60)	
Bexarotene	☐ 75 mg Capsule	***BSA Required: _____m^2*** ☐ Take _____ mg by mouth once daily with food (Quantity: QS 30 days) — ***RECOMMENDED DOSING*** 300 mg/m^2/day-taken as one daily dose	
	☐ 1% Gel 60 gm	**INITIAL:** Quantity: 1 tube ☐ Week 1: Apply to affected area(s) once every **other** day as directed ☐ Week 2: Apply to affected area(s) once daily as directed ☐ Week 3: Apply to affected area(s) twice daily as directed ☐ Week 4: Apply to affected area(s) three times daily as directed ☐ Week 5: Apply to affected area(s) four times daily as directed **MAINTENANCE:** ☐ Apply to affected area(s) _____ times daily as directed (Quantity: 1 tube)	
Capecitabine	☐ 150 mg Tablet ☐ 500 mg Tablet	***BSA Required: _____m^2*** ☐ Take____ mg PO twice daily on days 1-14 of a 21 day cycle, then repeat (Quantity: QS for 21 day cycle) ☐ Take ____ mg PO twice daily for ____ days with ____ days off, then repeat (Quantity: ____)	
Dasatinib	☐ 20 mg Tablet ☐ 50 mg Tablet ☐ 70 mg Tablet ☐ 80 mg Tablet	☐ Take ____ mg PO once daily (Quantity: _____) ***WEIGHT REQUIRED*** _____	
	☐ 100 mg Tablet	☐ Take 100 mg PO once daily (Quantity: 30)	
	☐ 140 mg Tablet	☐ Take 140 mg PO once daily (Quantity: 30)	
Deferasirox	☐ 90 mg Tablet ☐ 180 mg Tablet ☐ 360 mg Tablet	☐ Take ____ mg PO once daily (Quantity: _____) ***WEIGHT REQUIRED*** _____	
Other: _____	_____	_____ (Quantity: _____)	

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	☐ **C50.**_____ Malignant neoplasm of breast	☐ **C61** Malignant neoplasm of prostate
☐ **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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