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 E-Z

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
Erlotinib	☐ 25 mg Tablet	☐ Take ____ mg PO once daily on an empty stomach (Quantity: _____)	
	☐ 100 mg Tablet	☐ Take 100 mg PO once daily on an empty stomach (Quantity: 30)	
	☐ 150 mg Tablet	☐ Take 150 mg PO once daily on an empty stomach (Quantity: 30)	
Everolimus	☐ 10 mg Tablet	☐ Take 10 mg PO once daily (Quantity: 28)	
	☐ 5 mg Tablet ☐ 7.5 mg Tablet	*****BSA Required:** _____m^{2***} ☐ Take ____ mg PO once daily (Quantity: _____)	
Fulvestrant	250 mg/5 mL Pre-filled Syringe	☐ **INITIAL:** Inject 500 mg (two 250 mg injections) IM on days 1, 15, and 29 (Quantity: 6) ☐ **MAINTENANCE:** Inject 500 mg (two 250 mg injections) IM every 4 weeks (Quantity: 2)	
Imatinib	☐ 100 mg Tablet ☐ 400 mg Tablet	☐ Take 100 mg PO once daily with food (Quantity: 30) ☐ Take 400 mg PO once daily with food (Quantity: 30) ☐ Take 600 mg (SIX 100 mg tablets) PO once daily with food (Quantity: 180) ☐ Take 400 mg PO twice daily with food (Quantity: 60) ☐ Take ____ mg PO once daily with food (Quantity: ____) *****PEDIATRIC: BSA Required:** _____m^{2***}	
Lapatinib	250 mg Tablet	☐ Take 1250 mg (five 250 mg tablets) PO once daily on an empty stomach (Quantity: 150) ☐ Take 1500 mg (six 250 mg tablets) PO once daily on an empty stomach (Quantity: 180)	
Nilutamide	150 mg Tablet	☐ **INITIAL:** Take 300 mg (two 150 mg tablets) PO once daily for 30 days (Quantity: 60) ☐ **MAINTENANCE:** Take 150 mg PO once daily (Quantity: 30)	
Pazopanib	200 mg Tablet	☐ Take 800 mg (four 200 mg tablets) PO once daily on an empty stomach (Quantity: 120)	
Sorafenib	200 mg Tablet	☐ Take 400 mg (two 200 mg tablets) PO twice daily on an empty stomach (Quantity: 120)	
Sunitinib	☐ 12.5 mg Capsule ☐ 25 mg Capsule ☐ 37.5 mg Capsule ☐ 50 mg Capsule	☐ Take ____mg PO once daily (Quantity: _____) ☐ Take 37.5 mg PO once daily (Quantity: 28) ☐ Take 50 mg PO once daily (Quantity: 28)	
Temozolomide	☐ 5 mg Capsule ☐ 20 mg Capsule ☐ 100 mg Capsule ☐ 140 mg Capsule ☐ 180 mg Capsule ☐ 250 mg Capsule	*****BSA Required:** _____m^{2***} ☐ Take ____ mg PO once daily for 5 days every 28 days (Quantity: _____) ☐ Take ____ mg PO once daily for ____ days with ____days off (Quantity: _____)	
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**____ _____	☐ **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.**_____ _____	☐ **C91.0**___Acute lymphoblastic leukemia (ALL)	☐ **C92.1**___Chronic Myeloid Leukemia, BCR/ABL-positive	☐ **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

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.