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

Gout Enrollment Form

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

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

Drug		**Directions & Quantity**	**Refills**
Krystexxa®	☐ 8 mg Vial	☐ Infuse 8 mg intravenously (IV) every two weeks over no less than 120 minutes (Quantity: 2 doses)	

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 Discontinuing:**
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

Baseline Serum Uric Acid Level: _____mg/dL

Date of Diagnosis: _____/_____/_____

Current Serum Uric Acid Level: _____mg/dL

Allergies:

☐ **M1A.00X0** Idiopathic chronic gout, unspecified site, *without* tophus (tophi)

☐ **M1A.00X1** Idiopathic chronic gout, unspecified site, *with* tophus (tophi)

☐**M1A.**_____ _____

☐ **Other:** _____

Additional Clinical Information:

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

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