Faxed prescriptions will only be accepted from a prescribing practitioner. 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

Juvenile Idiopathic Arthritis (JIA) Enrollment Form I - Z

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
Kevzara®	200 mg Pre-filled Syringe	☐ Inject 200 mg SQ every 2 weeks	***WEIGHT REQUIRED*** _____ ***Intended for weight ≥ 63 kg/138 lbs***	**2**	
Orencia®	☐ 250 mg Vial **WEIGHT REQUIRED:** _____	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV on week 0, 2, and 4 ☐ **MAINTENANCE:** Infuse _____ mg via IV every 4 weeks	***WEIGHT BASED GUIDELINES:*** (<75 kg: 10 mg/kg) (75 kg-100 kg: 750 mg) (≥100 kg: 1000 mg)	**QS: 3 doses** **QS: 1 dose**	
	☐ Pre-filled Syringe ☐ ClickJect ™	**SUBCUTANEOUS (SQ):** ☐ Inject 50 mg SQ once weekly **(10 kg to less than 25 kg)** ☐ Inject 87.5 mg SQ once weekly **(25 kg to less than 50 kg)** ☐ Inject 125 mg SQ once weekly **(≥50 kg)**	***WEIGHT REQUIRED*** _____	**4**	
Rinvoq®	15mg Tablet	☐ Take 15 mg PO once daily **(≥30 kg)**	***WEIGHT REQUIRED*** _____	**30**	
Rinvoq® LQ	1 mg/mL Solution	☐ Take 3 mg PO twice daily **(10 kg to less than 20 kg)** ☐ Take 4 mg PO twice daily **(20 kg to less than 30 kg)** ☐ Take 6 mg PO twice daily **(≥40 kg)**		**1 bottle** **1 bottle** **2 bottles**	
Stelara®	☐ 45 mg Vial	☐ **INITIAL:** Inject ___ mg (0.75 mg/kg x___kg) SQ at weeks 0 & 4 ☐ **MAINTENANCE:** Inject ___ mg (0.75 mg/kg x___kg) SQ every 12 weeks	***WEIGHT REQUIRED*** _____ ***Intended for weight < 60 kg/132 lbs***	**QS: 2 doses** **QS: 1 dose**	
	☐ 45 mg Pre-filled Syringe	☐ **INITIAL:** Inject 45 mg SQ at weeks 0 & 4 ☐ **MAINTENANCE:** Inject 45 mg SQ every 12 weeks	***Intended for weight ≥ 60 kg/132 lbs***	**2** **1**	
	☐ 90 mg Pre-filled Syringe	☐ **INITIAL:** Inject 90 mg SQ at weeks 0 & 4 ☐ **MAINTENANCE:** Inject 90 mg SQ every 12 weeks	***Intended for weight > 100 kg/220 lbs with co-existent moderate-to-severe plaque psoriasis***	**2** **1**	
Xeljanz®	5 mg Tablet	☐ Take 5 mg PO twice daily	***WEIGHT REQUIRED*** _____	**60**	
	1 mg/mL Solution	☐ Take 3.2 mg PO twice daily **(10 kg to less than 20 kg)** ☐ Take 4 mg PO twice daily **(20 kg to less than 40 kg)** ☐ Take 5 mg PO twice daily **(≥40 kg)**		**240**	

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	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Meloxicam	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Date of Diagnosis: ___/___/___ Allergies: _____

☐ M08.00 Unspecified Juvenile Idiopathic Arthritis of Unspecified Site
☐ L40.54 Psoriatic juvenile arthropathy (JPsA)
☐ M08.09 Unspecified juvenile rheumatoid arthritis, multiple sites (pcJIA)
☐ Other: _____

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 Rx 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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