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

Oral Multiple Sclerosis 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

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/_____ ☐**No** **SHIP TO:** ☐**Patient's Home** ☐**Doctor's Office** ☐**Other:** _____

Drug		Directions & Quantity	Refills
Dalfampridine *(Ampyra®)*	10 mg Tablet	☐ Take 10 mg by mouth twice daily (Quantity: 60)	
Teriflunomide *(Aubagio®)*	☐ 7 mg Tablet	☐ Take 7 mg by mouth once daily (Quantity: 30)	
	☐ 14 mg Tablet	☐ Take 14 mg by mouth once daily (Quantity: 30)	
Gilenya®	**Manufacturer Requirement: Complete the Gilenya Start Form for prescription at** https://www.gilenyahcp.com/		
Mayzent®	**Manufacturer Requirement: Complete the Mayzent Start Form for prescription at** https://mayzenthcp.com/		
Dimethyl Fumarate *(Tecfidera®)*	☐120 mg Capsule	☐ **INITIAL:** Take 120 mg by mouth twice daily for 7 days (Quantity: 14)	
	☐240 mg Capsule	☐ **MAINTENANCE:** Take 240 mg by mouth twice daily (Quantity: 60)	
Zeposia®	☐7-day Starter Pack ☐28-day Starter Kit	☐ **INITIAL:** Take as directed per package instructions (Quantity: QS) ☐ All required assessments are completed and the patient is cleared for therapy	
	☐0.92 mg Capsule	☐ **MAINTENANCE:** Take 0.92 mg by mouth once daily starting on day 8 and thereafter (Quantity: 30) **For assistance with pre-assessments visit:** https://www.zeposiaportal.com/zeposiaprovider	

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY LAB NOTES REGARDING THERAPY*****

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Contraindication:
	____/____/_____ - ____/____/_____	
	____/____/_____ - ____/____/_____	
	____/____/_____ - ____/____/_____	
	____/____/_____ - ____/____/_____	

Date of Diagnosis: ____/_____/_____
☐G35 Multiple Sclerosis
☐Other: _____

Type: ☐ Relapsing-remitting ☐ Primary-progressive ☐Secondary-progressive ☐ Progressive-relapsing

Number of relapses in the past year: _____

Date of last MRI: ____/_____/_____

Were there any changes with the latest MRI? ☐Yes ☐ No

Is this patient nursing or planning pregnancy? ☐Yes ☐ No

Allergies:

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.

PRODUCT SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN
X_____ Date: ____/____/_____	X _____ Date: ____/____/_____

CONFIDENTIALITY NOTICE