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

Miscellaneous Immunology 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
Infusion Supplies	☐ 100 mL NS IV bag ☐ 250 mL NS IV bag		
☐ **Actemra®** ☐ **Avtozma®** ☐ **Tofidence®** ☐ **Tyenne®**	☐ 80 mg Vial ☐ 200 mg Vial ☐ 400 mg Vial	☐ Infuse _____ mg via IV over 1 hour every 4 weeks (Quantity: QS 1 dose)	
Cosentyx®	☐ 125 mg Vial Weight Required: _____	☐ **INITIAL:** Infuse 6 mg/kg via IV over 30 minutes at week 0 (Quantity: QS 1 dose) ☐ **MAINTENANCE:** Infuse 1.75 mg/kg via IV over 30 minutes every 4 weeks thereafter (Quantity: QS 1 dose) ***Max. 300 mg/infusion***	
☐ **Remicade®** ☐ **Avsola®** ☐ **Inflectra®** ☐ **Renflexis®** ☐ **Infliximab**	☐ 100 mg Vial	☐ **INITIAL:** Infuse _____ mg **OR** _____ mg/kg via IV at weeks 0, 2, and 6 (Quantity: QS 3 doses) ☐ **MAINTENANCE:** Infuse _____ mg **OR** _____ mg/kg via IV every _____ weeks thereafter (Quantity: QS 1 dose)	
☐ **Rituxan®** ☐ **Riabni®** ☐ **Ruxience®** ☐ **Truxima®**	☐ 100 mg/10 mL Vial ☐ 500 mg/50 mL Vial	☐ Infuse _____ mg on ☐ Day 1 and Day 15 ☐ Once a week for 4 weeks ☐ Other:_____ 100 mg Vial Quantity: _____ 500 mg Vial Quantity: _____	
Simponi Aria®	☐ 50 mg Vial Weight Required: _____ Height Required: _____	☐ **INITIAL:** Infuse 2 mg/kg via IV over 30 minutes at weeks 0 and 4 (Quantity: QS 2 doses) ☐ **MAINTENANCE:** Infuse 2 mg/kg via IV over 30 minutes every 8 weeks thereafter (Quantity: QS 1 dose) ☐ **INITIAL:** Infuse 80 mg/m² via IV over 30 minutes at weeks 0 and 4 (Quantity: QS 2 doses) ☐ **MAINTENANCE:** Infuse 80 mg/m² via IV over 30 minutes every 8 weeks thereafter (Quantity: QS 1 dose) ***Dosing intended for JIA***	

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

☐ C71 Functional disorders of polymorphonuclear neutrophils (CGD)	☐ K50.90 Crohn's disease, unspecified, without complications
☐ D89.839 Cytokine release syndrome, grade unspecified	☐ L10.0 Pemphigus Vulgaris
☐ K51.90 Ulcerative colitis, unspecified, without complications	☐ L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
☐ L40.0 Psoriasis Vulgaris	☐ M06.9 Rheumatoid Arthritis, unspecified
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, unspecified	☐ M31.7 Microscopic polyangiitis
☐ M08.00 Unspecified Juvenile Idiopathic Arthritis of Unspecified Site	☐ M45.A0 Non-Radiographic Axial Spondyloarthritis (Nr-axSpA) of unspecified sites in spine
☐ M31.30 Granulomatosis with polyangiitis (Wegener's)	☐ Q78.2 Osteopetrosis
☐ M45.9 Ankylosing Spondylitis, unspecified	☐ Other: _____

Date of Diagnosis: ____/____/_____ **Allergies:** _____

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 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

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.