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®** ☐ **Tyenne®**	☐ 80 mg Vial ☐ 200 mg Vial ☐ 400 mg Vial	☐ Infuse _____ mg **OR** 8 mg/kg via IV over 1 hour (Quantity: QS 1 dose) ☐ Infuse _____ mg **OR** 12 mg/kg via IV over 1 hour (Quantity: QS 1 dose)	
Benlysta®	☐ 120 mg/5 mL Vial ☐ 400 mg/20 mL Vial	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____mg or 10 mg/kg via IV over 1 hour every 2 weeks, for 3 doses (Quantity: QS 3 doses) ☐ **MAINTENANCE:** Infuse _____ mg OR 10 mg/kg via IV over 1 hour every 4 weeks (Quantity: QS 1 dose)	
	☐ 200 mg Autoinjector ☐ 200 mg Pre-filled syringe	**SUBCUTANEOUS (SQ):** ☐ **INITIAL:** Inject 400 mg SQ (two 200 mg injections) once weekly for four weeks (Quantity: 8) ***Dosing intended for LN*** ☐ **MAINTENANCE:** Inject 200 mg SQ every week (Quantity: 4) ☐ Inject 200 mg SQ every week (Quantity: 4)	
	☐ 200 mg Autoinjector	☐ Inject 200 mg SQ every week (Quantity: 4) ***Intended for SLE patients 5-17 years old & ≥ 40 kg/88 lbs *** ☐ Inject 200 mg SQ once every 2 weeks (Quantity: 4) ***Intended for SLE patients 5-17 years old & 15 kg/33 lbs to < 40 kg/88 lbs ***	
Cosentyx®	☐ 125 mg Vial Weight Required: _____	☐ **INITIAL:** Infuse 6 mg/kg via IV over 30 minutes at week 0 (Quantity: QS 1 dose) ***Max. 300 mg/infusion*** ☐ **MAINTENANCE:** Infuse 1.75 mg/kg via IV over 30 minutes every 4 weeks thereafter (Quantity: QS 1 dose)	
☐ **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/m^2 via IV over 30 minutes at weeks 0 and 4 (Quantity: QS 2 doses) ***Dosing intended for JIA*** ☐ **MAINTENANCE:** Infuse 80 mg/m^2 via IV over 30 minutes every 8 weeks thereafter (Quantity: QS 1 dose)	

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)
- ☐ D89.839 Cytokine release syndrome, grade unspecified
- ☐ K51.90 Ulcerative colitis, unspecified, without complications
- ☐ L40.0 Psoriasis Vulgaris
- ☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, unspecified
- ☐ M08.00 Unspecified Juvenile Idiopathic Arthritis of Unspecified Site
- ☐ M31.30 Granulomatosis with polyangiitis (Wegener's)
- ☐ M32.10 Systemic Lupus Erythematosus, organ or system involvement unspecified
- ☐ M45.9 Ankylosing Spondylitis, unspecified
- ☐ K50.90 Crohn's disease, unspecified, without complications
- ☐ L10.0 Pemphigus Vulgaris
- ☐ L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
- ☐ M06.9 Rheumatoid Arthritis, unspecified
- ☐ M31.7 Microscopic polyangiitis
- ☐ M32.14 Glomerular disease in systemic lupus erythematosus (Lupus Nephritis)
- ☐ M45.A0 Non-Radiographic Axial Spondyloarthritis (Nr-axSpA) of unspecified sites in spine
- ☐ Q78.2 Osteopetrosis
- ☐ 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