

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.



3712 E. Plano Parkway, Ste. 200 Plano, TX 75074

This prescription form is to be sent & received via fax

Pediatric Asthma/Respiratory 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 | Strength | Directions & Quantity | Refills |
|-----------|---|---|---------|
| Dupixent® | <input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Pen | PEDIATRIC ASTHMA (ages 12 to 17): <input type="checkbox"/> INITIAL: Inject 400 mg SQ (two 200 mg injections) at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every other week starting at day 15 (Quantity: 2) | |
| | <input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen | <input type="checkbox"/> INITIAL: Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every other week starting at day 15 (Quantity: 2) | |
| | <input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen | PEDIATRIC ASTHMA (ages 6 to 11): ***WEIGHT REQUIRED*** _____ <input type="checkbox"/> Inject 300 mg SQ every four weeks (Quantity: 2) ***Intended for weight 15 kg/33 lbs to < 30 kg/66 lbs*** | |
| | <input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Pen | <input type="checkbox"/> Inject 200 mg SQ every other week (Quantity: 2) ***WEIGHT REQUIRED*** _____ ***Intended for weight ≥ 30 kg/66 lb*** | |
| | <input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen | PEDIATRIC CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSwNP) (ages 12 to 17): <input type="checkbox"/> Inject 300 mg SQ every other week (Quantity: 2) | |
| | <input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen | PEDIATRIC ALLERGIC FUNGAL RHINOSINUSITIS (AFRS) (ages 12 to 17): <input type="checkbox"/> Inject 300 mg SQ every four weeks (Quantity: 2) ***WEIGHT REQUIRED*** _____ ***Intended for weight 15 kg/33 lbs to < 30 kg/66 lbs*** <input type="checkbox"/> Inject 300 mg SQ every other week (Quantity: 2) ***WEIGHT REQUIRED*** _____ ***Intended for weight ≥ 60 kg/132 lbs | |
| | <input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Pen | <input type="checkbox"/> Inject 200 mg SQ every other week (Quantity: 2) ***WEIGHT REQUIRED*** _____ ***Intended for weight 30 kg/66 lbs to < 60 kg/132 lbs*** | |

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: | Therapy Contraindications: |
|--|----------------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> Short-acting beta-agonist (SABA): _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Inhaled corticosteroids with long-acting beta-agonist (ICS/LABA) combination therapy: _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Inhaled corticosteroids (without LABA): _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Long-acting muscarinic antagonist (LAMA): _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Leukotriene receptor antagonist (LTRA): _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Oral/injectable corticosteroids: _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Other controller (specify): _____ | <input type="checkbox"/> (_____) | <input type="checkbox"/> | _____ |

IgE Level: _____ Date: ___/___/___ Number of severe exacerbations past 12 months: _____

Eosinophil levels: _____ cells/mcl. Date: ___/___/___ Patient has moderate to severe asthma that requires add-on maintenance treatment

Patient has had prior sinus surgery Date: ___/___/___ Patient is not a candidate for surgery Rationale: _____

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

| | | |
|---|--|--|
| <input type="checkbox"/> J30.89 Other allergic rhinitis | <input type="checkbox"/> J32.9 Chronic sinusitis, unspecified | <input type="checkbox"/> J33.0 Polyp of Nasal Cavity |
| <input type="checkbox"/> J33.9 Nasal Polyp, unspecified | <input type="checkbox"/> J45.40 Moderate Persistent Asthma, uncomplicated | <input type="checkbox"/> J45.41 Moderate Persistent Asthma w/ acute exacerbation |
| <input type="checkbox"/> J45.50 Severe Persistent Asthma, uncomplicated | <input type="checkbox"/> J45.51 Severe Persistent Asthma w/ acute exacerbation | <input type="checkbox"/> Other: _____ |

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 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

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.