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
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

Purified Cortrophin Gel 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

☐ **New** ☐ **Refill** **Ship by:**____/____/_____ **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:**_____

Drug	**Directions & Quantity**				**Refills**
Purified Cortrophin® Gel	☐ 5mL multidose vial	**Dose:** _____ ☐ Units ☐ mL	**Route of Administration:** ☐ IM ☐ SQ	**Schedule/Frequency:** _____ _____	**Quantity of Vials:**
Supplies	☐ Sharps Container ☐ Syringe ☐ Needles	☐ 1cc syringe ☐ 23 G x 1" ☐ 25 G x 5/8"			**Quantity:** _____ **Quantity:** _____ **Quantity:** _____

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES & LAB WORK PERTINENT TO THERAPY*****

PREVIOUS THERAPIES:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ **M06.9** Rheumatoid Arthritis, unspecified
☐ **M33.20** Polymyositis, organ involvement unspecified
☐ **M45.9** Ankylosing Spondylitis of unspecified sites in spine
☐ **D86.9** Sarcoidosis, unspecified
☐ Other: _____

☐ **M33.90** Dermatopolymyositis, unspecified, organ involvement unspecified
☐ **M32.10** Systemic lupus erythematosus, organ or system involvement unspecified
☐ **M08.00** Unspecified Juvenile Rheumatoid Arthritis of unspecified site
☐ **L40.50** Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)

☐ **G35** Multiple Sclerosis **Is Cortrophin to be used to treat an acute exacerbation?** ☐ **Yes** ☐ **No (If yes, please provide date of onset: ___/___/_____)**
☐ Other: _____

☐ **R80.9** Proteinuria (Please indicate etiology):
☐ Other: _____

☐ Focal Segmental Glomerular Sclerosis (FSGS)
☐ Lupus Nephritis (LN)
☐ Minimal change disease (MCD)
☐ IgA Nephropathy (IgAN)
☐ Membranous Nephropathy (MN)

☐ **H16.9** Keratitis, unspecified
☐ **H46.9** Optic Neuritis, unspecified
☐ **H30.009** Chorioretinitis and Focal Retinochoroiditis
☐ Other: _____

☐ **H20.9** Iridocyclitis (Uveitis), unspecified
☐ **H30.90** Unspecified Chorioretinal inflammation, unspecified eye (Choroiditis)
☐ **H16.409** Unspecified Corneal Neovascularization, unspecified eye

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

History of Corticosteroid Use

A corticosteroid was tried with the following response(s):	**A corticosteroid was *not* tried due to the following response(s):**
☐ Patient hypersensitive or allergic	☐ Corticosteroid use is contraindicated for this patient
☐ Patient intolerant to corticosteroids	☐ Patient has known intolerance to corticosteroids
☐ Corticosteroid use failed, but same response not expected with Cortrophin Gel	☐ Intravenous access is not possible for this patient
☐ Previous corticosteroids tried were: ☐ Oral ☐ IV	☐ 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

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