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
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent & received via fax

Gastrointestinal Enrollment Form A-H

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
Cimzia®	☐ 200 mg Pre-filled Syringe ☐ 200 mg Vial	☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)	
Dupixent®	☐ 300 mg Pre-filled Syringe ☐ 300 mg Pen	☐ Inject 300 mg SQ every week (Quantity: 4) ***WEIGHT REQUIRED*** _____ ***Intended for ages 12 and older with weight ≥ 40 kg/88 lbs***	
Entyvio®	☐ 300 mg Vial	☐ **INITIAL:** Infuse 300 mg IV over 30 minutes at Day 0, 14, and 42 (Quantity: 3) ☐ **MAINTENANCE:** Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1)	
Humira® *Citrate Free*	☐ 80 mg/0.8 mL Crohn's/UC Starter Kit ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ 80 mg/0.8 mL Crohn's Starter Kit	**PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 15, then 20 mg every **other** week starting on day 29 (Quantity: 2)	
	☐ 20 mg/0.2 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for weight 17 kg/37 lbs to <40 kg/88 lbs***	
	☐ 80 mg/0.8 mL Crohn's Starter Kit ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ***Intended for weight ≥40 kg/88 lbs***	
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	**PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, 40 mg on day 15 (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week starting on day 29 (Quantity: 2) ***Intended for weight 20 kg/44 lbs to <40 kg/88 lbs***	
	☐ 20 mg/0.2 mL Pre-filled Syringe	☐ **MAINTENANCE:** Inject 20 mg SQ every week starting on day 29 (Quantity: 4)	
	☐ 80 mg/0.8 mL Pediatric UC Starter Kit ☐ 80 mg/0.8 mL Pen ☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 8, 80 mg on day 15 (Quantity: 4) ☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week starting on day 29 (Quantity: 2) ***Intended for weight ≥40 kg/88 lbs*** ☐ **MAINTENANCE:** Inject 40 mg SQ every week starting on day 29 (Quantity: 4)	

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:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Pentasa	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ K20.0 Eosinophilic Esophagitis
☐ K50.00 Crohn's disease of small intestine, without complications
☐ K50.80 Crohn's disease of both intestines, without complications
☐ K51.50 Left-sided Ulcerative Colitis, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ K20. ___ _____
☐ K50.10 Crohn's disease of large intestine, without complications
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.80 Other Ulcerative Colitis, without complications
☐ Other: _____

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

Active TB is ruled out: ☐Yes ☐No Date: ____/____/_____ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/_____

☐Patient is steroid dependent

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.