



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

SQ/IM Immune Globulin Enrollment Form

**Physician Offices Call:
855-460-7928**

Fax: 888-777-5645

Prescriber:		NPI:
Supervising Physician:		NPI:
Address:		Tax ID:
Phone:	Fax:	
Contact:		

This prescription form is to be sent & received via fax

PATIENT INFORMATION

Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: ____/____/____	SS#: ____-____-____
Street:	City:	State:	Zip: ____-____-____
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

<input type="checkbox"/> New <input type="checkbox"/> Refill	Ship by: ____/____/____	SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____	
Prescription	Drug	Dose, Directions, & Quantity	Refills
Immune Globulin Products	<input type="checkbox"/> Hizentra® 20%		
	<input type="checkbox"/> Xembify® 20%		
	<input type="checkbox"/> Gammaked™ 10%		
	<input type="checkbox"/> Gammagard Liquid® 10%		
	<input type="checkbox"/> Gamunex-C® 10%		
Other Medications	<input type="checkbox"/> Gamastan® S/D 16.5%		
	<input type="checkbox"/> Acetaminophen		
	<input type="checkbox"/> Diphenhydramine		
	<input type="checkbox"/> Lidocaine 2.5% & Prilocaine 2.5% Cream 30 gram		

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:	Reason(s) for Discontinuing:
<input type="checkbox"/> _____	<input type="checkbox"/> (_____) _____	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____) _____	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____) _____	<input type="checkbox"/>	_____

Diagnosis (ICD-10): _____	Date of Diagnosis: ____/____/____	Allergies:
IgA Deficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No	IgA level: _____ mg/dL Date: ____/____/____	
IgG trough: _____ mg/dL Date: ____/____/____		

Additional Clinical Information:

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: ____/____/____
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CONFIDENTIALITY NOTICE

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