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

Rheumatology 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**
Actemra®	☐ ACTPen® ☐ Pre-filled Syringe ☐ Vials ☐ 80 mg ☐ 200 mg ☐ 400 mg	☐ **IV:** Infuse ______ mg **OR** _____ mg/kg via IV every 4 weeks (Quantity: ___) ☐ **SQ:** Inject 162 mg SQ every **other** week (Quantity: 2) ☐ **SQ:** Inject 162 mg SQ every week (Quantity: 4)	
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Enbrel®	☐ SureClick Pen ☐ Mini® with AutoTouch® ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	☐ Inject 50 mg SQ every week (Quantity: 4) ☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8)	
Humira®	☐ Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ weekly (Quantity: 4)	
Citrate Free	☐ Pen	☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week (Quantity: 2)	

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	☐ (__________________)	☐	________________________________
☐ Plaquenil	☐ (__________________)	☐	________________________________
☐ Naproxen / Aleve	☐ (__________________)	☐	________________________________
☐ Tramadol	☐ (__________________)	☐	________________________________
☐ Enbrel	☐ (__________________)	☐	________________________________
☐ Humira	☐ (__________________)	☐	________________________________
☐ Cimzia	☐ (__________________)	☐	________________________________
☐ __________________	☐ (__________________)	☐	________________________________
☐ __________________	☐ (__________________)	☐	________________________________

☐ H20.9 Unspecified Iridocyclitis
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M31.6 Other Giant Cell Arteritis
☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
☐ D89.83___ Cytokine Release Syndrome, Grade___
☐ H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites
☐ M05.79 Rheumatoid Arthritis with rheumatoid factor of mult. sites w/o organ or system involvement
☐ 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

__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.