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 I - Z

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
Kevzara®	☐ 150 mg Pre-filled Syringe ☐ 150 mg Pen	☐ Inject 150 mg SQ every 2 weeks (Quantity: 2)	
	☐ 200 mg Pre-filled Syringe ☐ 200 mg Pen	☐ Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Olumiant®	☐ 2 mg Tablets	☐ Take 2 mg PO once daily (Quantity: 30)	
Orencia®	☐ 250 mg Vials ☐ Pre-filled Syringe ☐ ClickJect™	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV on week 0, 2, and 4(Quantity: QS 3 doses) ☐ **MAINTENANCE:** Infuse _____ mg via IV every 4 weeks (Quantity: QS 1 dose) **SUBCUTANEOUS (SQ):** ☐ Inject 125mg SQ once weekly (Quantity: 4)	
Otezla®	☐ 28 Day Starter Pack	☐ Take as directed per package instructions (Quantity: 55)	
	☐ 30 mg Tablets	☐ Take 30 mg PO twice daily (Quantity: 60)	
Rinvoq™	15 mg Tablets	☐ Take 15 mg PO once daily (Quantity: 30)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month (Quantity: 1)	
Xeljanz®	5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)	

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	☐(_____)	☐	_____
☐ Enbrel	☐(_____)	☐	_____
☐ Humira	☐(_____)	☐	_____
☐ Cimzia	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M05.79 Rheumatoid Arthritis with Rheumatoid Factor of mult. sites w/o organ or system inolvement
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites
☐ M35.2 Behcet's disease
☐ M35.3 Polymyalgia Rheumatica
☐ 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

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