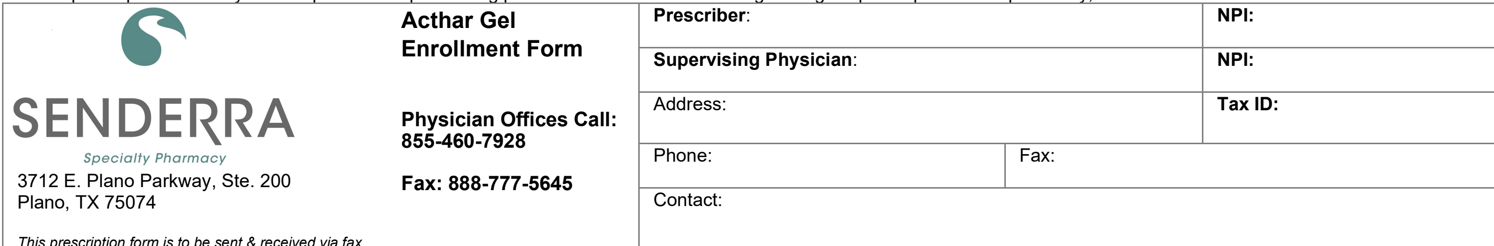
Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



Acthar Gel Enrollment Form

SENDERRA Specialty Pharmacy
3712 E. Plano Parkway, Ste. 200
Plano, TX 75074

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

This prescription form is to be sent & received via fax

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
Acthar® 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 Acthar to be used to treat an acute exacerbation?** ☐ **Yes** ☐ **No (If yes, please provide date of onset: ___/___/______)**
☐ Other: ____________________________

☐ **G40.821** Infantile Spasms, *with* intractable epilepsy
☐ **G40.822** Infantile Spasms *without* intractable epilepsy
Has diagnosis been confirmed by EEG? ☐ **Yes** ☐ **No**
☐ Other: ____________________________

☐ **R80.9** Proteinuria (Please indicate etiology):
☐ Focal Segmental Glomerular Sclerosis (FSGS)
☐ Lupus Nephritis
☐ IgA Nephropathy (IgAN)
☐ Membranous Nephropathy (MN)
☐ Other: ____________________________

☐ **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):
☐ Patient hypersensitive or allergic
☐ Patient intolerant to corticosteroids
☐ Corticosteroid use failed, but same response not expected with Acthar Gel
☐ Previous corticosteroids tried were: ☐ Oral ☐ IV

A corticosteroid was *not* tried due to the following response(s):
☐ Corticosteroid use is contraindicated for this patient
☐ Patient has known intolerance to corticosteroids
☐ Intravenous access is not possible for this patient
☐ 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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