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

3712 E. Plano Parkway, Ste. 200
Plano, TX 75074

This prescription form is to be sent & received via fax

Gout Enrollment Form

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

☐ **New** ☐**Refill** | **Ship by: ____/____/____** | **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other: _____**

Drug		Directions & Quantity	Refills
Krystexxa®	☐ 8 mg Vial	☐ Infuse 8 mg intravenously (IV) every two weeks over no less than 120 minutes (Quantity: 2 doses)	
Uloric *(Febuxostat)*	☐ 40 mg Tablet ☐ 80 mg Tablet	☐ Take 40 mg PO once daily with or without food (Quantity: 30) ☐ Take 80 mg PO once daily with or without food (Quantity: 30)	
ColciGel®	☐ 15 mL ☐ 30 mL (2 Pak)	☐ Apply 1-4 pumps up to four times per day (Quantity: 1)	

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:
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

Date of Diagnosis: _____/_____/_____

Baseline Serum Uric Acid Level: _____mg/dL

Current Serum Uric Acid Level: _____mg/dL

Allergies:

☐ **M1A.00X0** Idiopathic chronic gout, unspecified site, *without* tophus (tophi)

☐ **M1A.00X1** Idiopathic chronic gout, unspecified site, *with* tophus (tophi)

☐ **M1A.**_____ _____

☐ **Other:** _____

Additional Clinical Information:

PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED

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.

PRODUCT SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN
X _____ Date: ____/____/____	**X** _____ 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.