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.

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

This prescription form is to be sent & received via fax

Hemophilia 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:** _______________

Factor I (Recombinant)	☐ RiaSTAP®
Factor VIIa (Recombinant)	☐ NovoSeven® RT ☐ Sevenfact®
Factor VIII (Recombinant)	☐ Advate® ☐ Adynovate® ☐ Afstyla® ☐ Eloctate™ ☐ Esperoct® ☐ Jivi® ☐ Kogenate® FS ☐ Kovaltry® ☐ NovoEight® ☐ Nuwiq® ☐ Recombinate® ☐ Xyntha®
Factor VIII (Human)	☐ Hemofil® M ☐ Monarc-M™
Factor VIII (Human) + VWF	☐ Alphanate® SD ☐ Humate-P® ☐ Koāte® DVI ☐ Wilate®
Factor IX (Recombinant)	☐ Alprolix® ☐ Benefix® RT ☐ Idelvion® ☐ Ixinity® ☐ Rixubis®
Factor IX (Human)	☐ AlphaNine® SD ☐ Proplex T
Factor X Activator (Human/Recombinant)	☐ Hemlibra®
Factor XIII (Human)	☐ Corifact®
Factor XIII (Recombinant)	☐ Tretten®
Von Willebrand Factor (Recombinant)	☐ Vonvendi®
Anti-Inhibitor (Factor)	☐ Feiba®
Pro-Thrombin Complex (Human)	☐ Profilnine® SD

Therapy Regimen for Factor or Inhibitor Products			
	☐ Prophylaxis________/week	☐ Breakthrough Bleed	☐ Immune Tolerance
	☐ Target Dose: _____IU/kg	☐ Minor: _______IU ± ____%	☐ Target Dose: _____IU/kg
	☐ Dose: _____IU ± ____%	☐ Moderate: _______IU ± ____%	☐ Dose: _____IU ± ____%
	(Assay Variation)	☐ Major: _______IU ± ____%	(Assay Variation)
	# of Doses:_______ Refills:_____	# of Doses:_______ Refills:_____	# of Doses:_______ Refills:_____

Flushing Protocol	☐ Sodium Chloride 0.9% 5-10 mL pre and post medications ☐ Heparin_______ Units/mL _______mL as needed
Ancillary Supplies	☐ As needed for proper administration and proper disposal of medication and infusion supplies
Skilled Nursing Visits	☐ As needed for IV access, administration, and proper clinical monitoring

All nursing services requirements to be completed per pharmacy protocol

Other Medications		
	☐ Amicar®	Directions:________________________________Qty:______ Refills: ______
	☐ Lysteda®	Directions:________________________________Qty:______ Refills: ______
	☐ Stimate®	Directions:________________________________Qty:______ Refills: ______
	☐ ________	Directions:________________________________Qty:______ Refills: ______

MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

Circulating Factor:________% **Target Joints:** ☐ No ☐ Yes _______ **Severity:** ☐ Severe (<1%) ☐ Moderate (1-5%) ☐ Mild (>5%)

Inhibitor Activity: ☐ None ☐ Historical ☐ Current _______BU/mL **Access:** ☐ Peripheral ☐ PICC ☐ Implanted Port ☐ Other:_____________

Protocol: ☐ Pre-surgical ☐ Prophylaxis ☐ Immune Tolerance ☐ On-demand **Start date:** ____/____/________ **End date:** _____/____/________

Diagnosis Date: ____/____/________ **Allergies:** ____

☐ **D66** Type A- Factor VIII Deficiency ☐ **D67** Type B- Factor IX Deficiency ☐ **D68.1** Type C- Factor XI Deficiency

☐ **D68.2** Hereditary deficiency of other clotting factors ☐ **D68.32** Hemorrhagic disorder due to extrinsic circulating anticoagulants ☐ **D68.4** Acquired coagulation factor deficiency

☐ **D68.0.** Von Willebrand Disease (Type: ☐ 1 ☐ 2 ☐ 3) ☐ **Other:** ____

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.