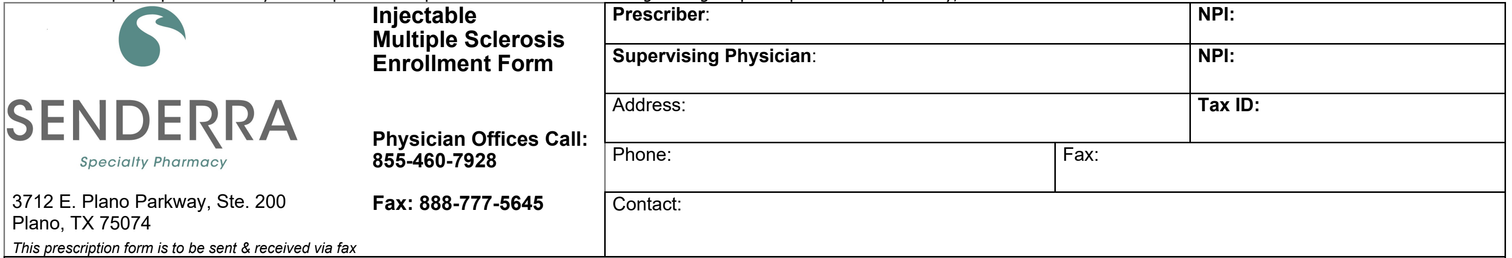
Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.




**Injectable Multiple Sclerosis Enrollment Form**

**Physician Offices Call: 855-460-7928**

**Fax: 888-777-5645**

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

*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

**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 |
|---|---|---|---|
| **Avonex®** | ☐30 mcg Pre-filled Syringe | ☐ Inject 7.5 mcg IM at week 1, 15 mcg IM at week 2, 22.5 mcg IM at week 3, and 30 mcg IM weekly starting at week 4 (Quantity:4) | |
| | ☐30 mcg Autoinjector<br>☐30 mcg Pre-filled Syringe | ☐ Inject 30 mcg IM once weekly (Quantity: 4) | |
| **Betaseron®** | ☐0.3 mg Vial | ☐ **INITIAL:**<br>Weeks 1-2: Inject 0.0625 mg/0.25 ml SQ every other day (Quantity:7)<br>Weeks 3-4: Inject 0.125 mg/0.5 ml SQ every other day (Quantity: 7)<br>Weeks 5-6: Inject 0.1875 mg/0.75 ml SQ every other day (Quantity:7)<br>Weeks 7+: Inject 0.25 mg/1 ml SQ every other day (Quantity: 7)<br>☐ **MAINTENANCE:** Inject 0.25 mg/1 ml SQ every other day (Quantity: 14) | |
| **Copaxone®** *(Glatopa/glatiramer acetate)* | ☐20 mg Pre-filled Syringe | ☐ Inject 20 mg SQ every day (Quantity: 30) | |
| | ☐40 mg Pre-filled Syringe | ☐ Inject 40 mg SQ 3 times per week at least 48 hours apart (Quantity: 12) | |
| **Extavia®** | ☐0.3 mg Vial | ☐ **INITIAL:**<br>Weeks 1-2: Inject 0.0625 mg/0.25 ml SQ every other day (Quantity: 7)<br>Weeks 3-4: Inject 0.125 mg/0.5 ml SQ every other day (Quantity: 8)<br>Weeks 5-6: Inject 0.1875 mg/0.75 ml SQ every other day (Quantity: 7)<br>Weeks 7+: Inject 0.25 mg/1 ml SQ every other day (Quantity: 8)<br>☐ **MAINTENANCE:** Inject 0.25mg/1 ml SQ every other day (Quantity: 15) | |
| **Kesimpta®** | ☐20 mg Sensoready Pen | ☐ **INITIAL:** Inject 20 mg SQ at week 0, 1, & 2 (Quantity: 3)<br>☐ **MAINTENANCE:** Inject 20 mg SQ once monthly, starting at week 4 (Quantity: 1) | |
| **Plegridy®** | ☐Pre-filled Syringe Starter pack<br>☐Pen Starter pack | **SUBCUTANEOUS (SQ):**<br>☐ **INITIAL:** Inject 63 mcg **SQ** on day 1, and 94 mcg on day 15 (Quantity: 2) | |
| | ☐125 mcg Pre-filled Syringe<br>☐125 mcg Pen | ☐ **MAINTENANCE:** Inject 125 mcg **SQ** starting on day 29, and every 14 days thereafter (Quantity: 2) | |
| | ☐125 mcg Pre-filled Syringe | **INTRAMUSCULAR (IM):**<br>☐ **INITIAL:** Inject 63 mcg **IM** on day 1, and 94 mcg on day 15 using the device clip (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 125 mcg **IM** starting on day 29, and every 14 days thereafter (Quantity: 2) | |
| **Rebif®** | ☐Pre-filled Syringe Titration pack<br>☐Auto Injector Titration pack | ☐ **INITIAL:** 44 mcg titration protocol<br>Weeks 1-2: Inject 8.8 mcg SQ three times per week at least 48 hours apart (Quantity: 6)<br>Weeks 3-4: Inject 22 mcg SQ three times per week at least 48 hours apart (Quantity: 6) | |
| | ☐Autoinjector ☐Pre-filled Syringe | ☐ **MAINTENANCE:** Inject 44 mcg SQ three times per week at least 48 hours apart (Quantity: 12) | |
| | ☐Titration pack (Pre-filled Syringe only) | ☐ **INITIAL:** 22 mcg titration protocol<br>Weeks 1-2: Inject 4.4 mcg SQ three times per week at least 48 hours apart (Quantity: 6)<br>Weeks 3-4: Inject 11 mcg SQ three times per week at least 48 hours apart (Quantity: 6) | |
| | ☐Autoinjector ☐Pre-filled Syringe | ☐ **MAINTENANCE:** Inject 22 mcg SQ three times per week at least 48 hours apart (Quantity: 12) | |

## MEDICAL INFORMATION

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

| PREVIOUS THERAPIES: | Tried & Failed (Duration): | Contraindication: |
|---|---|---|
| | ____/____/________ - ____/____/________ | |
| | ____/____/________ - ____/____/________ | |
| | ____/____/________ - ____/____/________ | |

| | | |
|---|---|---|
| **Date of Diagnosis:** ____/______/________<br>☐G35 Multiple Sclerosis<br>☐Other: ________________<br>**Type:** ☐ Relapsing-remitting ☐Primary-progressive ☐ Secondary-progressive ☐ Progressive-relapsing | **Number of relapses in the past year:** __________<br>**Date of last MRI:** ____/______/________<br>**Were there any changes with the latest MRI?**<br>☐Yes ☐ No | **Is this patient nursing or planning pregnancy?**<br>☐Yes ☐ No<br>**Allergies**: |

**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 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.