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

This prescription form is to be sent & received via fax

Miscellaneous Therapy Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Office:	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**
Adcirca®* (*tadalafil*)	☐ 20 mg Tablet		
Aldurazyme®*	☐ 2.9 mg/5 mL Vial		
Botox®*	☐ 50 unit Vial ☐ 100 unit Vial ☐ 200 unit Vial		
Cerezyme®*	☐ 400 unit Vial		
Dysport®*	☐ 300 unit Vial ☐ 500 unit Vial		
Elaprase®*	☐ 6 mg/3 mL Vial		
Epoprostenol Sodium*	☐ 0.5 mg Vial ☐ 1.5 mg Vial		
Fabrazyme®*	☐ 5 mg Vial ☐ 35 mg Vial		
Myobloc®*	☐ 2,500 unit/0.5 mL Vial ☐ 5,000 unit/1 mL Vial ☐ 10,000 unit/2 mL Vial		
Revatio®* (*sildenafil*)	☐ 10 mg/mL oral suspension ☐ 20 mg Tablet ☐ 10 mg/12.5 mL Vial		
Soliris®*	☐ 300 mg/30 mL Vial		
Vpriv®*	☐ 400 unit Vial		
Xiaflex®*	☐ 0.9 mg Vial		

**Senderra will dispense upon prescriber request*

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:**
☐ ______________________	☐(_______________)	☐	___________________________
☐ ______________________	☐(_______________)	☐	___________________________
☐ ______________________	☐(_______________)	☐	___________________________

Diagnosis (ICD-10): ______________________ **Date of Diagnosis**: ____/____/________

Allergies:

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.