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

Ophthalmology 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

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
Acthar® Gel	☐ 5mL multi-dose vial	**Dose:** _____ ☐Units ☐ mL	**Route of Administration:** ☐IM ☐ SQ	**Schedule/Frequency:** _____ _____	**Quantity of Vials:**	
Humira® *Citrate Free*	☐ Adult Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)				
	☐ Pre-filled Syringe	**PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ Inject 10 mg SQ every **other** week **(10 kg to <15 kg)** (Quantity: 2) ☐ Inject 20 mg SQ every **other** week **(15 kg to <30 kg)** (Quantity: 2)				
	☐ Pen ☐ Pre-filled Syringe	☐ Inject 40 mg SQ every **other** week **(≥ 30 kg)** (Quantity: 2)				
Purified Cortrophin® Gel	☐ 1mL multi-dose vial ☐ 5mL multi-dose vial	**Dose:** _____ ☐Units ☐ mL	**Route of Administration:** ☐IM ☐ SQ	**Schedule/Frequency:** _____ _____	**Quantity of Vials:**	
Retisert®*	☐ 0.59 mg Implant					
Supplies	☐ Sharps Container ☐ Syringe ☐ Needles	☐ 1cc syringe ☐ 23 G x 1" ☐ 25 G x 5/8"			**Quantity:** _____ **Quantity:** _____ **Quantity:** _____	

**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:	Contraindication:
☐ Acular	☐ (_____)	☐	_____
☐ Voltaren	☐ (_____)	☐	_____
☐ Prednisone	☐ (_____)	☐	_____
☐ Methylprednisolone	☐ (_____)	☐	_____
☐ Methotrexate	☐ (_____)	☐	_____
☐ Azathioprine	☐ (_____)	☐	_____
☐ Remicade	☐ (_____)	☐	_____
☐	☐ (_____)	☐	_____

☐ H16.409 Unspecified Corneal Neovascularization, unspecified eye
☐ H20.0 Iridocyclitis (Uveitis), unspecified acute and subacute
☐ H30.009 Chorioretinitis and Focal Retinochoroiditis
☐ H46.9 Optic Neuritis, unspecified
☐ H16.9 Keratitis, unspecified
☐ H20.9 Iridocyclitis (Uveitis), unspecified
☐ H30.90 Unspecified Chrorioretinal inflammation, unspecified eye (Choroiditis)
☐ Other: _____

Date of Diagnosis: ____/____/_____ **Allergies:** _____ ☐Patient is steroid dependent

Active TB is ruled out: ☐Yes ☐No Date: ____/____/_____ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/_____

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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