

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

**Pediatric
Asthma/Respiratory
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:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: ____/____/____	SS#: ____-____-____
Street:	City:	State:	ZIP: ____-____-____
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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	Strength	Directions & Quantity	Refills
Dupixent®	<input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Pen	ADOLESCENT (ages 12 to 17): <input type="checkbox"/> INITIAL: Inject 400 mg SQ (two 200 mg injections) at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every other week starting at day 15 (Quantity: 2)	
	<input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen	<input type="checkbox"/> INITIAL: Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every other week starting at day 15 (Quantity: 2)	
	<input type="checkbox"/> 300 mg Pre-filled Syringe <input type="checkbox"/> 300 mg Pen	PEDIATRIC (ages 6 to 11): <input type="checkbox"/> Inject 300 mg SQ every four weeks (Quantity: 2) ***WEIGHT REQUIRED*** _____ ***Intended for weight 15 kg/33 lbs to < 30 kg/66 lbs***	
	<input type="checkbox"/> 200 mg Pre-filled Syringe <input type="checkbox"/> 200 mg Pen	<input type="checkbox"/> Inject 200 mg SQ every other week (Quantity: 2) ***WEIGHT REQUIRED*** _____ ***Intended for weight ≥ 30 kg/66 lb***	
Nucala®	<input type="checkbox"/> 100 mg Vial <input type="checkbox"/> 100 mg Autoinjector	ADOLESCENT (ages 12 to 17): <input type="checkbox"/> Inject 100 mg SQ once every 4 weeks (Quantity: 1)	
	<input type="checkbox"/> 100 mg Vial	PEDIATRIC (ages 6 to 11): <input type="checkbox"/> Inject 40 mg SQ once every 4 weeks (Quantity: 1)	
	<input type="checkbox"/> 40 mg Pre-filled Syringe		

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:	Therapy Contraindications:
<input type="checkbox"/> Short-acting beta-agonist (SABA): _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Inhaled corticosteroids with long-acting beta-agonist (ICS/LABA) combination therapy: _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Inhaled corticosteroids (without LABA): _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Long-acting muscarinic antagonist (LAMA): _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Leukotriene receptor antagonist (LTRA): _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Oral/injectable corticosteroids: _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Other controller (specify): _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____

IgE Level: _____ Date: ____/____/____ Number of severe exacerbations past 12 months: _____

Eosinophil levels: _____ cells/mL Date: ____/____/____ Patient has moderate to severe asthma that requires add-on maintenance treatment

Patient has had prior sinus surgery Date: ____/____/____ Patient is not a candidate for surgery Rationale: _____

Date of Diagnosis: ____/____/____ **Allergies:** _____

J45.40 Moderate Persistent Asthma, uncomplicated J45.41 Moderate Persistent Asthma w/ acute exacerbation J45.50 Severe Persistent Asthma, uncomplicated

J45.51 Severe Persistent Asthma w/ acute exacerbation Other: _____

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

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.