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

1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

Rheumatology Enrollment Form A - H

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
Actemra®	☐ ACTPen® ☐ Pre-filled Syringe ☐ Vials ☐ 80 mg ☐ 200 mg ☐ 400 mg	☐ **IV:** Infuse _____ mg **OR** _____ mg/kg via IV every 4 weeks (Quantity: ___) ☐ **SQ:** Inject 162 mg SQ every **other** week (Quantity: 2) ☐ **SQ:** Inject 162 mg SQ every week (Quantity: 4)	
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Enbrel®	☐ SureClick Pen ☐ Mini® with AutoTouch® ☐ Pre-filled Syringe	☐ Inject 50 mg SQ every week (Quantity: 4)	
Humira® ***Citrate Free***	☐ Uveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS 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) ☐ **MAINTENANCE:** Inject 40 mg SQ weekly (Quantity: 4)	
	☐ Pen	☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week (Quantity: 2)	

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:**
☐ Methotrexate	☐ (_____)	☐	_____
☐ Plaquenil	☐ (_____)	☐	_____
☐ Naproxen / Aleve	☐ (_____)	☐	_____
☐ Tramadol	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐	☐ (_____)	☐	

☐ H20.9 Unspecified Iridocyclitis
☐ H20.0 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M31.6 Other Giant Cell Arteritis
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites
☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
☐ M05.79 Rheumatoid Arthritis with rheumatoid factor of mult. sites w/o organ or system involvement
☐ D89.83___ Cytokine Release Syndrome, Grade___
☐ Other: _____

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

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

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.