Faxed prescriptions will only be accepted from a prescribing practitioner. 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
Main Tel: 888-777-5547
Fax: 888-777-5645

Acthar Enrollment

Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	
Office:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F	DOB: ____/____/_____	SS#: ____-____-_____
Tel: / Al. Tel:	☐ English ☐ Spanish ☐ Other: _____		Wt.: _____ Ht.: _____
Street: / City:	State:	ZIP:	

MEDICAL INFORMATION

Previously Failed:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Date of Diagnosis: ___/___/_____

- ☐ **M06.9 Rheumatoid Arthritis**
- ☐ **M33.90 Dermatomyositis**
- ☐ **L40.5 Psoriatic Arthritis**
- ☐ **D86.9 Sarcoidosis**
- ☐ **G35 Multiple Sclerosis**
  - **Is Acthar to be used to treat an acute exacerbation?** ☐ **Yes** ☐ **No** (If Yes, date of onset: __/___/_____)
- ☐ **G40.822 Infantile spasm, without intractable epilepsy**
  - **Has diagnosis been confirmed by EEG?** ☐ **Yes** ☐ **No**
- ☐ **G40.821 Infantile spasm, with intractable epilepsy**
  - **Has diagnosis been confirmed by EEG?** ☐ **Yes** ☐ **No**
- ☐ **M32 System Lupus Erythematosus (SLE)**
- ☐ **M33.2 Polymyositis**
- ☐ **M45.9 Ankylosing Spondylitis**
- ☐ **M08.0 Juvenile Rheumatoid Arthritis**
- ☐ **R80.9 Proteinuria**
  - **Please indicate etiology:** ☐ **Focal segmental glomerular sclerosis** ☐ **IgA nephropathy** ☐ **Lupus nephritis** ☐ **Membranous nephropathy**
- ☐ **H16.9 Keratitis, Unspecified**
- ☐ **H44.139 Sympathetic Uveitis, Unspecified**
- ☐ **H46.9 Optic Neuritis, Unspecified**
- ☐ **H20.0 Iridocyclitis, Unspecified acute and subacute**
- ☐ **H30.009 Chorioretinitis and focal Retinochoroiditis**
- ☐ **H16.4 Corneal Neovascularization, Unspecified**
- ☐ **Other:** _____

Allergies:

History of Corticosteroid Use

A corticosteroid was tried with the following response(s):

- ☐ Patient hypersensitive or allergic
- ☐ Patient intolerant to corticosteroids
- ☐ Corticosteroid use failed, but same response not expected with Acthar
- ☐ Other:_____

_____

OR

A corticosteroid was not tried due to the following response(s):

- ☐ Corticosteroid use is contraindicated for this patient
- ☐ Patient has known intolerance to corticosteroids
- ☐ Intravenous access is not possible for this patient
- ☐ Other:_____

_____

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

PRESCRIPTION

☐ **New** ☐ **Refill** | **Ship by:** ____/____/_____ | **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug		Directions & Quantity				Refills
Acthar®	☐ 5mL multidose vial	**Dose:** _____ ☐ Units ☐ mL	**Route of Administration:** ☐ IM ☐ SQ	**Schedule/Frequency:** _____ _____	**Quantity:**	
Supplies	☐ Sharps Container ☐ Syringe ☐ Needles	☐ 1cc syringe ☐ 23 G x 1" ☐ 25 G x 5/8"	**Quantity:** **Quantity:** **Quantity:**			

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Senderra Rx to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Senderra Rx to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: **Date**: ____/____/_____

CONFIDENTIALITY NOTICE