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: 888-777-5547
Fax: 888-777-5645
E-mail: info@senderrarx.com

Gastrointestinal Enrollment

Prescribing Practitioner:

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

DMARDS:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Methotrexate	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
5 ASA:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Pentasa	☐ (_____)	☐	_____
☐ Entocort	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
SPECIALTY drugs:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Other:
☐ Patient is steroid dependent
☐ Other: _____

Active TB is ruled out: ☐ Yes ☐ No
Hep B ruled out or being treated: ☐ Yes ☐ No

Allergies:_____

Date of Diagnosis: ____/____/____

☐ K50.00 Crohns Disease
☐ K50.10 Regional enteritis of large intestine
☐ K50.80 Regional enteritis of small intestine with large intestine
☐ K50.91 Regional enteritis of unspecified site
☐ K51.80 Ulcerative enterocolitis
☐ K51.80 Ulcerative ileocolitis
☐ K51.50 Left-sided ulcerative colitis
☐ K51.60 Universal ulcerative colitis
☐ K51.90 Ulcerative colitis, unspecified
☐ 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
Cimzia®	☐ Prefilled Syringe ☐ Lyophilized Powder	☐ **INITIAL:** Inject 400mg SQ on day 1, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200mg SQ every 2 weeks (Quantity: 2)	
Entyvio™	☐ Vials	☐ **INITIAL**: Infuse _____mg over 30 minutes on day 0, 14, and 42 (Quantity:_____) ☐ **MAINTENANCE:** Infuse _____mg over 30 minutes every 8 weeks (Quantity:_____)	
Humira®	☐ Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160mg SQ on day 1, then 80mg on day 14 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40mg SQ every other week (Quantity: 2)	
Remicade®	☐ Vials	☐ **INITIAL**: Infuse _____mg on day 0, 14, and 42 (Quantity: _____) ☐ **MAINTENANCE:** Infuse _____mg every 8 weeks (Quantity: _____)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 200mg SQ on day 1, then 100mg on day 14 (Quantity: 3) ☐ **MAINTENANCE:** Inject 100mg SQ every 4 weeks (Quantity: 1)	

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