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

Hemophilia 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

☐ D66 (Type A – Factor VIII Deficiency)
☐ D68.0 (Von Willebrand Disease – Check Type ☐ 1 ☐ 2 ☐ 3
☐ D68.2 (Hereditary deficiency of other clotting factors)
☐ D68.4 (Acquired coagulation factor deficiency)
☐ D67 (Type B – Factor IX – Deficiency)
☐ D68.1 (Type C – Factor XI Deficiency)
☐ D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants)
☐ Other:

Circulating Factor _____%
Severity: ☐ Severe (<1%) ☐ Moderate (1 - 5%) ☐ Mild (>5%)
Inhibitor Activity: ☐ None ☐ Historical ☐ Current _____BU/mL
Target Joints: ☐ No ☐ Yes _____
Access: ☐ Peripheral Butterfly ☐ PICC ☐ Implant Port ☐ Broviac®/Hickman®
Protocol: ☐ Pre-Surgical ☐ Prophylaxis ☐ Immune Tolerance ☐ On-demand
Allergies:
Comorbidities:
Concomitant Medications:

PRESCRIPTION

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

Factor VIIa (Recombinant)	☐ NovoSeven® RT	Directions:
Factor VIII (Recombinant)	☐ Advate® ☐ Adynovate® ☐ Eloctate™ ☐ Helixate® FS ☐ Kogenate® FS ☐ NovoEight® ☐ Recombinate® ☐ Xyntha®	
Factor VIII (Human)	☐ Hemofil® M ☐ Monclate-P® ☐ Nuwiq®	
Factor VIII (Human) + VWF	☐ Alphanate® SD ☐ Humate-P® ☐ Koāte® DVI ☐ Wilate®	
Factor IX (Recombinant)	☐ Alprolix® ☐ Benefix® RT ☐ Ixinity® ☐ Rixubis®	
Factor IX (Human)	☐ AlphaNine® SD ☐ Mononine®	
Factor X (Human)	☐ Coagadex®	
Factor XIII (Human)	☐ Corifact®	Qty:
VWF (Recombinant)	☐ Vonvendi™	
Anti-Inhibitor (Human)	☐ Feiba®	Refills:
Pro-Thrombin Complex (Human)	☐ Bebulin® VH ☐ Profilnine® SD	

Therapy Regimen for Factor or Inhibitor Products

☐ Prophylaxis _____/week	☐ Breakthrough bleed	☐ Immune Tolerance
☐ Target Dose: _____ IU/kg	☐ Minor: _____IU ± ____%	☐ Target Dose: _____ IU/kg
☐ Dose: _____ IU ± ____%	☐ Moderate: _____IU ± ____%	☐ Dose: _____ IU ± ____%
(Assay variation)	☐ Major: _____IU ± ____%	(Assay variation)
# Doses: _____ Refills: ____	# Doses: _____ Refills: _____	# Doses: _____ Refills: _____

Flushing Protocol	☐ Sodium Chloride 0.9% 5-10 mL pre and post medications	☐ Heparin _____Units/mL _____mL as needed
Ancillary Supplies	☐ As needed for proper administration and disposal of medication	
Skilled Nursing Visits	☐ As needed for IV access, administration and proper clinical monitoring	

All nursing services requirements to be completed per pharmacy protocol.

Other Medications	☐ Amicar® ☐ Lysteda® ☐ Stimate® ☐ Other:	Directions:	Qty:	Refills:

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

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