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

Intravenous Immunoglobulin 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

ICD-10/Diagnosis Code:

Date of Diagnosis: _____	Has patient received immune globulin previously? ☐ Yes ☐ No
IgA deficiency: ☐ Yes ☐ No IgA level _____ mg/dL Date:_____	If yes, product information: _____
IgG trough:_____mg/dL Date:_____ Diabetic: ☐ Yes ☐ No	Date of last infusion: _____ Date of next infusion: _____

Comorbidities:	**Concomitant Medications:**	**Allergies:**

PRESCRIPTION

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

Immune Globulin Products

☐ Bivigam® 10% ☐ Carimune® NF ☐ Flebogamma® 5% ☐ Flebogamma® 10%
☐ GammaKed® 10% ☐ Gammagard® Liquid10% ☐ Gammaplex® 5% ☐ Gammagard® S/D
☐ Gamunex-C® 10% ☐ Octagam® 5% ☐ Octagam® 10% ☐ Privigen® 10%
☐ IVIG (Pharmacy to determine)

Therapy Regimen

Dose: _____ g/kg Total dose: _____ grams
Daily for _____ days every _____ weeks
Doses: _____ Refills: _____
Administration Rate: ☐ Per manufacture guidelines, as tolerated ☐ _____

Pre-Medications and Pre-Protocol

☐ Diphenhydramine _____mg 30 min before infusion
☐ PO ☐ IVP
☐ Acetaminophen _____mg 30 min before infusion PO
☐ Other: _____
☐ Other: _____

☐ Hydration Infuse _____ mL _____ solution
☐ Prior to ☐ During ☐ Following
☐ Solu-Cortef® _____ mg slow IVP
☐ Solu-Medrol® _____ mg slow IVP
☐ Pre ☐ Halfway ☐ Upon completion

Flushing Protocol

☐ Sodium Chloride 0.9% 5-10 mL pre and post medications ☐ Heparin _____Units/mL _____mL as needed

Anaphylaxis Orders and Medications

Orders: ☐ Stop infusion ☐ Call 911 and prescribing physician ☐ Administer medications below as per protocol

☐ Diphenhydramine Administer 25-50 mg slow IV/IM
Dispense: 1 x 50 mg vial

☐ Epinephrine ☐ Administer 0.3 mg (1:1000) Sub-Q (≥ 30 Kg) ☐ Administer 0.15 mg (1:2000) Sub-Q (< 30 Kg)
Dispense: 1 vial

☐ Sodium Chloride 0.9% Use as directed per the protocol
Dispense: 1 x 500 mL Bag

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.

*****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