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SENDERRA
Specialty Pharmacy

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

Main Tel: 888-777-5547
Fax: 888-777-5645

Rheumatology Enrollment

Prescription Information

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:

PRESCRIPTION

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

Drug		Directions & Quantity	Refills
Actemra®	☐ Vials ☐ Pre-filled Syringe	☐ **IV:** Infuse _____mg **OR** _____ mg/kg via IV every 4 weeks (Quantity: 28 days) ☐ **SQ:** Inject 162mg SQ every **other** week (Quantity: 2) ☐ **SQ:** Inject 162mg SQ every week (Quantity: 4)	
Cimzia®	☐ Pre-filled Syringe ☐ Lyophilized Powder	☐ **INITIAL:** Inject 400mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200mg SQ every 2 weeks (Quantity: 2)	
Cosentyx(TM)	☐ Sensoready Pen	☐ **INITIAL:** Inject 150mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 150mg SQ every 4 weeks (Quantity: 1)	
	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 300mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) ☐ **MAINTENANCE:** Inject 300mg SQ every 4 weeks (Quantity: 2)	
Enbrel®	☐ SureClick® Pen 50 mg ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	☐ Inject 50 mg SQ every week (Quantity: 4) ☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8)	
Humira®	☐ Pen ☐ Pre-filled Syringe	☐ **MAINTENANCE:** Inject 40mg SQ every **other** week (Quantity: 2) ☐ **MAINTENANCE:** Inject 40mg SQ weekly (Quantity: 4)	
Methotrexate	☐ 2.5mg tablet ☐ 25mg/mL 2mL Inj Solution	☐ Take ___ mg PO every week (Quantity: 28 day supply) ☐ Inject ___ mL / ___mg SQ every 7 days the same day each week (Quantity: 28 day supply)	
Orencia®	☐ Vials ☐ Pre-filled Syringe	☐ **INITIAL:** Infuse _____mg via IV, then inject 125mg SQ within 24 hours (Quantity: ___) ☐ **MAINTENANCE:** Inject 125mg SQ weekly (Quantity: 4)	
Otezla®	☐ Titration Starter Pack	☐ Take as directed (Quantity: 55) **These directions can only be selected for the Titration Starter Pack**	
	☐ Maintenance	☐ Take 30 mg PO twice daily (Quantity: 60) ☐ Take 30 mg PO once daily (Quantity: 30)	
	☐ Bridge Dose Pack	☐ Take 30 mg PO twice daily (Quantity: 28) (12 refills) ☐ Take 30 mg PO once daily (Quantity: 28) (6 refills)	
Otrexup	☐ 7.5 mg Auto Inj ☐ 15 mg Auto Inj ☐ 20 mg Auto Inj ☐ 25 mg Auto Inj ☐ 10 mg Auto Inj ☐ 17.5mg Auto Inj ☐ 22.5 mg Auto Inj	☐ Inject ___ mg SQ every week (Quantity: 4)	
Rasuvo™	☐ 7.5 mg Auto Inj ☐ 15 mg Auto Inj ☐ 22.5 mg Auto Inj ☐ 10 mg Auto Inj ☐ 17.5 mg Auto Inj ☐ 25 mg Auto Inj ☐ 30 mg Auto Inj ☐ 12.5 mg Auto Inj ☐ 20 mg Auto Inj ☐ 27.5 mg Auto Inj	☐ Inject ___ mg SQ every week (Quantity: 4)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50mg SQ once a month (Quantity: 1)	
Stelara®	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 45 mg SQ on Day 0 & Day 28 (Quantity: 2) ☐ **MAINTENANCE:** Inject 45 mg SQ every 12 weeks (Quantity: 1)	
	Weight Required: _____	☐ **INITIAL:** Inject 90 mg SQ on Day 0 & Day 28 (Quantity: 2) ☐ **MAINTENANCE:** Inject 90 mg SQ every 12 weeks (Quantity: 1) **** Weight must be greater than 220lbs ****	
Xeljanz®	5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)	

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

COMPLETE PAGE 2 WITH CLINICAL INFORMATION

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Clinical Information

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

PATIENT INFORMATION

Name:	DOB: _____/_____/_____

MEDICAL INFORMATION

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

DMARDS:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐Methotrexate	☐ (_____)	☐	_____
☐Sulfasalazine	☐ (_____)	☐	_____
☐Plaquenil	☐ (_____)	☐	_____
☐_____	☐ (_____)	☐	_____

NSAIDs:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐Naproxen / Aleve	☐ (_____)	☐	_____
☐Meloxicam	☐ (_____)	☐	_____
☐Tramadol	☐ (_____)	☐	_____
☐_____	☐ (_____)	☐	_____

SPECIALTY drugs:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Enbrel	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Date of Diagnosis:

_____/_____/_____

- ☐ M06.9 Rheumatoid Arthritis
- ☐ M08.0 Juvenile Rheumatoid Arthritis
- ☐ L40.5 Psoriatic Arthritis
- ☐ M45.9 Ankylosing Spondylitis
- ☐ Other: _____

Active TB is ruled out: ☐Yes ☐No

Hep B ruled out/treated: ☐Yes ☐No

Allergies:_____

Additional Clinical Information: