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

Xolair Enrollment

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

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

TOPICAL Agents	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Hydrocortisone	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Asthma Therapies:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Short-acting beta-agonist (SABA)	☐ (_____)	☐	_____
☐ Inhaled corticosteroids (ICS without LABA) Long-acting beta-agonist (LABA without ICS) Combination therapy (ICS/LABA)	☐ (_____)	☐	_____
☐ Oral and/or injectable steroids	☐ (_____)	☐	_____
☐ H1 antihistamines	☐ (_____)	☐	_____
☐ Proton Pump Inhibitor (specify):	☐ (_____)	☐	_____
☐ Other (specify):	☐ (_____)	☐	_____

☐ ER visits/hospitalizations Date: ____/____/_____ ☐ Unscheduled office visits Date: ____/____/_____

☐ Moderate to severe allergic persistent asthma Date: ____/____/_____

Asthma Lab Values:

Serum total IgE level: _____(IU/mL) Date drawn: ____/____/_____

Pretreatment FEV_1 %_____ Date drawn: ____/____/_____

Allergy Lab Values:

RAST Result? ☐ Positive ☐ Negative Date: ____/____/_____

In-Vivo allergy tests? ☐ Positive ☐ Negative Allergen: _____ Date: ____/____/_____

*** Per Xolair prescribing information, no lab values are necessary for Chronic Idiopathic Uticaria ***

Date of Diagnosis: ____/____/_____

☐ J45.40 Moderate persistent asthma, uncomplicated ☐ J45.50 Severe persistent asthma, uncomplicated

☐ L50.1 Idiopathic urticaria ☐ 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**
Xolair®	Vials	☐ Inject 150mg/dose every 4 weeks (1 vial) ☐ Inject 300mg/dose every 4 weeks (2 vials) ☐ Inject 225 mg/dose every 2 weeks (4 vials) ☐ Inject 300mg/dose every 2 weeks (4 vials) ☐ Inject 375 mg/dose every 2 weeks (6 vials)	

PHYSICIAN SIGNATURE

To Physician: 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.

Physician Signature: **Date**: _____/_____/_____

CONFIDENTIALITY NOTICE

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