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

*This prescription form is to be sent & received via fax*

**Acthar Gel Enrollment Form**

**Physician Offices Call: 855-460-7928**

**Fax: 888-777-5645**

| | |
|---|---|
| **Prescriber**: | **NPI:** |
| **Supervising Physician**: | **NPI:** |
| Address: | **Tax ID:** |
| Phone: | Fax: |
| Contact: | |

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name: | ☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other | DOB: ____/____/_____ | SS#: _____-____-_____ |
| Street: | City: | State: | Zip: |
| Phone: | Alt. Phone: | ☐ English ☐ Spanish ☐ Other: _____ | Wt.: _____ Ht.: _____ |

## PRESCRIPTION

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

| **Drug** | **Directions & Quantity** | | | | **Refills** |
|---|---|---|---|---|---|
| **Acthar® Gel** | ☐ 5mL multidose vial | **Dose:** _____ ☐ Units ☐ mL | **Route of Administration:** ☐ IM ☐ SQ | **Schedule/Frequency:** _____ _____ | **Quantity of Vials:** |
| **Supplies** | ☐ Sharps Container ☐ Syringe ☐ Needles | ☐ 1cc syringe ☐ 23 G x 1" ☐ 25 G x 5/8" | | **Quantity:** _____ **Quantity:** _____ **Quantity:** _____ | |

## MEDICAL INFORMATION

***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES & LAB WORK PERTINENT TO THERAPY***

| **PREVIOUS THERAPIES:** | **Tried & Failed (Duration):** | **Not Tolerated:** | **Contraindication:** |
|---|---|---|---|
| ☐ _____ | ☐ (_____) | ☐ | _____ |
| ☐ _____ | ☐ (_____) | ☐ | _____ |
| ☐ _____ | ☐ (_____) | ☐ | _____ |

☐ **M06.9** Rheumatoid Arthritis, unspecified
☐ **M33.20** Polymyositis, organ involvement unspecified
☐ **M45.9** Ankylosing Spondylitis of unspecified sites in spine
☐ **D86.9** Sarcoidosis, unspecified
☐ **M33.90** Dermatopolymyositis, unspecified, organ involvement unspecified
☐ **M32.10** Systemic lupus erythematosus, organ or system involvement unspecified
☐ **M08.00** Unspecified Juvenile Rheumatoid Arthritis of unspecified site
☐ **L40.50** Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
☐ Other: _____

☐ **G35** Multiple Sclerosis **Is Acthar to be used to treat an acute exacerbation?** ☐ **Yes** ☐ **No (If yes, please provide date of onset: ___/___/_____)**
☐ Other: _____

☐ **G40.821** Infantile Spasms, *with* intractable epilepsy ☐ **G40.822** Infantile Spasms *without* intractable epilepsy
**Has diagnosis been confirmed by EEG?** ☐ **Yes** ☐ **No**
☐ Other: _____

☐ **R80.9** Proteinuria (Please indicate etiology): ☐ Focal Segmental Glomerular Sclerosis (FSGS) ☐ Lupus Nephritis ☐ IgA Nephropathy (IgAN) ☐ Membranous Nephropathy (MN)
☐ Other: _____

☐ **H16.9** Keratitis, unspecified
☐ **H46.9** Optic Neuritis, unspecified
☐ **H30.009** Chorioretinitis and Focal Retinochoroiditis
☐ **H20.9** Iridocyclitis (Uveitis), unspecified
☐ **H30.90** Unspecified Chorioretinal inflammation, unspecified eye (Choroiditis)
☐ **H16.409** Unspecified Corneal Neovascularization, unspecified eye
☐ Other: _____

**Allergies:** _____ **Date of Diagnosis:** ____/____/_____

**History of Corticosteroid Use**

**A corticosteroid was tried with the following response(s):**
☐ Patient hypersensitive or allergic
☐ Patient intolerant to corticosteroids
☐ Corticosteroid use failed, but same response not expected with Acthar Gel
☐ Previous corticosteroids tried were: ☐ Oral ☐ IV

**A corticosteroid was *not* tried due to the following response(s):**
☐ Corticosteroid use is contraindicated for this patient
☐ Patient has known intolerance to corticosteroids
☐ Intravenous access is not possible for this patient
☐ Other: _____

Additional Clinical Information:

## INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ Senderra to coordinate injection training

## PRESCRIBER SIGNATURE

**To Prescriber:** By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

**Prescriber**: **Date**: _____/_____/_____

## CONFIDENTIALITY NOTICE

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