Faxed prescriptions will only be accepted from a prescriber. 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

Dermatologic Oncology Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 855-662-6779

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
Erivedge®	☐ 150 mg Capsules	☐ Take 150 mg once daily by mouth (Quantity: 28)	
Odomzo®	☐ 200 mg Capsules	☐ Take 200 mg once daily by mouth on an empty stomach, at least 1 hour before or 2 hours after a meal (Quantity: 30)	
Targretin® *(bexarotene)*	☐ 75 mg Capsules **BSA Required:** _____m^2	☐ Take _____ mg by mouth once daily with food (Quantity: QS 30 days) ***RECOMMENDED DOSING*** 300 mg/m^2/day-taken as one daily dose	
Targretin®	☐1% Gel 60 gm	**INITIAL:** Quantity: 1 tube ☐ Week 1: Apply to affected area(s) once every **other** day as directed ☐ Week 2: Apply to affected area(s) once daily as directed ☐ Week 3: Apply to affected area(s) twice daily as directed ☐ Week 4: Apply to affected area(s) three times daily as directed ☐ Week 5: Apply to affected area(s) four times daily as directed **MAINTENANCE:** ☐ Apply to affected area(s) _____ times daily as directed (Quantity: 1 tube)	

MEDICAL INFORMATION

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

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Reason(s) for Discontinuing:
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

Erivedge®

Please specify patient as: ☐locally advanced disease ☐metastatic disease

☐ Patient has basal cell carcinoma that has recurred following surgery

☐ Patient has basal cell carcinoma and is *not* a candidate for surgery and *not* a candidate for radiation

Odomzo®

☐ Patient has locally advanced basal cell carcinoma that has recurred following surgery

☐ Patient has locally advanced basal cell carcinoma and is *not* a candidate for surgery and *not* a candidate for radiation

Date of Diagnosis: _____/_____/_____

☐ **C44.91** Basal cell carcinoma, unspecified

☐ **C84.A0** Cutaneous T-cell lymphoma, unspecified, unspecified site

☐ **C44.____** _____

☐ **C84.A___** Cutaneous T-cell lymphoma, unspecified, _____

☐ **Other:** _____

Allergies:

Additional Clinical Information:

PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED

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.

PRODUCT SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN
X _____ Date: ____/____/_____	X _____ Date: ____/____/_____

CONFIDENTIALITY NOTICE