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*

**HIV A-L 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

**Has the patient received a loading dose/starter kit?** ☐ **Yes Start Date:** ____/____/_____ ☐ **No** | **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:**_____

| Drug | Strength & Quantity | Directions | Refills |
|---|---|---|---|
| ☐ **Aptivus®** | 250 mg Capsule (Quantity: _____) | | |
| ☐ **Atripla®** (efavirenz/emtricitabine/tenofovir)*** | 600/200/300 mg Tablet (Quantity: _____) | | |
| ☐ **Biktarvy®** | 50/200/25 mg Tablet (Quantity: _____) | | |
| **Cabenuva** | ☐ **INITIAL:** 600/900 mg Kit (Quantity: 1)<br>☐ **MAINTENANCE:** 400/600 mg Kit (Quantity: 1) | | |
| ☐ **Cimduo®** | 300/300 mg Tablet (Quantity: _____) | | |
| ☐ **Combivir** (lamivudine/zidovudine)*** | 150/300 mg Tablet (Quantity: _____) | | |
| ☐ **Complera®** | 200/25/300 mg Tablet (Quantity: _____) | | |
| ☐ **Delstrigo™** | 100/300/300 mg Tablet (Quantity: _____) | | |
| ☐ **Descovy®** | 200/25 mg Tablet (Quantity: _____) | | |
| ☐ **Dovato** | 50/300 mg Tablet (Quantity: _____) | | |
| ☐ **Edurant®** | 25 mg Tablet (Quantity: _____) | | |
| **Emtriva** (emtricitabine)*** WEIGHT REQUIRED: _____ | ☐ 200 mg Capsule (Quantity: _____)<br>☐ 10 mg/mL Solution (Quantity: _____) | | |
| **Epivir** (lamivudine)*** WEIGHT REQUIRED: _____ | ☐ 100 mg Tablet (Quantity: _____)<br>☐ 150 mg Tablet (Quantity: _____)<br>☐ 300 mg Tablet (Quantity: _____)<br>☐ 10 mg/mL Solution (Quantity: _____) | | |
| ☐ **Epzicom** (abacavir/lamivudine)*** | 600/300 mg Tablet (Quantity: _____) | | |
| ☐ **Evotaz®** | 300/150 mg Tablet (Quantity: _____) | | |
| ☐ **Fuzeon®** | 90 mg/mL Vial (Quantity: _____) | | |
| ☐ **Genvoya®** | 150/150/200/10 mg Tablet (Quantity: _____) | | |
| **Intelence®** (etravirine)*** WEIGHT REQUIRED: _____ | ☐ 25 mg Tablet (Quantity: _____)<br>☐ 100 mg Tablet (Quantity: _____)<br>☐ 200 mg Tablet (Quantity: _____) | | |
| ☐ **Invirase** | 500 mg Tablet (Quantity: _____) | | |
| **Isentress®** WEIGHT REQUIRED: _____ | ☐ 25 mg Chewable Tablet (Quantity: _____)<br>☐ 100 mg Granules (Quantity: _____)<br>☐ 100 mg Chewable Tablet (Quantity: _____)<br>☐ 400 mg Tablet (Quantity: _____) | | |
| ☐ **Isentress® HD** | 600 mg Tablet (Quantity: _____) | | |
| ☐ **Juluca** | 50/25 mg Tablet (Quantity: _____) | | |
| **Kaletra®** (lopinavir/ritonavir)*** | ☐ 80/20 mg/mL Solution (Quantity: _____)<br>☐ 100/25 mg Tablet (Quantity: _____)<br>☐ 200/50 mg Tablet (Quantity: _____) | | |
| ☐ **Lexiva** (fosamprenavir calcium)*** | 700 mg Tablet (Quantity: 60) | | |

## 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: | Contraindication: |
|---|---|---|---|
| ☐ _____ | ☐(_____) | ☐ | _____ |
| ☐ _____ | ☐(_____) | ☐ | _____ |

☐ B20 Human Immunodeficiency Virus (HIV) Disease ☐ Z20.6 Contact with and (suspected) exposure to HIV

☐ Other: _____

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

Additional Clinical Information:

## PRESCRIBER SIGNATURE---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

**IMPORTANT:** This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.