


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.

 <p>SENDERRA Specialty Pharmacy</p> <p>1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent & received via fax</i></p>	Injectable Multiple Sclerosis Enrollment Form		Prescriber: _____ NPI: _____
	Physician Offices Call: 855-460-7928		Supervising Physician: _____ NPI: _____
	Physician Offices Call: 855-460-7928		Address: _____ Tax ID: _____
	Fax: 888-777-5645		Phone: _____ Fax: _____ Contact: _____

PATIENT INFORMATION					
Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: / /	SS#:		
Street:	City:	State:	ZIP:		
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.:	Ht.:	

PRESCRIPTION			
Has the patient received a loading dose/starter kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date: / /	SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other:

Drug	Directions & Quantity	Refills
Avonex® <input type="checkbox"/> 30 mcg Pre-filled Syringe <input type="checkbox"/> 30 mcg Autoinjector <input type="checkbox"/> 30 mcg Pre-filled Syringe	<input type="checkbox"/> Inject 7.5 mcg IM at week 1, 15 mcg IM at week 2, 22.5 mcg IM at week 3, and 30 mcg IM weekly starting at week 4 (Quantity:4) <input type="checkbox"/> Inject 30 mcg IM once weekly (Quantity: 4)	
Betaseron® <input type="checkbox"/> 0.3 mg Vial	<input type="checkbox"/> INITIAL: Weeks 1-2: Inject 0.0625 mg/0.25 ml SQ every other day (Quantity:7) Weeks 3-4: Inject 0.125 mg/0.5 ml SQ every other day (Quantity: 7) Weeks 5-6: Inject 0.1875 mg/0.75 ml SQ every other day (Quantity:7) Weeks 7+: Inject 0.25 mg/1 ml SQ every other day (Quantity: 7) <input type="checkbox"/> MAINTENANCE: Inject 0.25 mg/1 ml SQ every other day (Quantity: 14)	
Copaxone® (Glatopa/glatiramer acetate) <input type="checkbox"/> 20 mg Pre-filled Syringe <input type="checkbox"/> 40 mg Pre-filled Syringe	<input type="checkbox"/> Inject 20 mg SQ every day (Quantity: 30) <input type="checkbox"/> Inject 40 mg SQ 3 times per week at least 48 hours apart (Quantity: 12)	
Extavia® <input type="checkbox"/> 0.3 mg Vial	<input type="checkbox"/> INITIAL: Weeks 1-2: Inject 0.0625 mg/0.25 ml SQ every other day (Quantity: 7) Weeks 3-4: Inject 0.125 mg/0.5 ml SQ every other day (Quantity: 8) Weeks 5-6: Inject 0.1875 mg/0.75 ml SQ every other day (Quantity: 7) Weeks 7+: Inject 0.25 mg/1 ml SQ every other day (Quantity: 8) <input type="checkbox"/> MAINTENANCE: Inject 0.25mg/1 ml SQ every other day (Quantity: 15)	
Kesimpta® <input type="checkbox"/> 20 mg Sensoready Pen	<input type="checkbox"/> INITIAL: Inject 20 mg SQ at week 0, 1, & 2 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 20 mg SQ once monthly, starting at week 4 (Quantity: 1)	
Plegridy® <input type="checkbox"/> Pre-filled Syringe Starter pack <input type="checkbox"/> Pen Starter pack <input type="checkbox"/> 125 mcg Pre-filled Syringe <input type="checkbox"/> 125 mcg Pen <input type="checkbox"/> 125 mcg Pre-filled Syringe	<input type="checkbox"/> SUBCUTANEOUS (SQ): <input type="checkbox"/> INITIAL: Inject 63 mcg SQ on day 1, and 94 mcg on day 15 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 125 mcg SQ starting on day 29, and every 14 days thereafter (Quantity: 2) <input type="checkbox"/> INTRAMUSCULAR (IM): <input type="checkbox"/> INITIAL: Inject 63 mcg IM on day 1, and 94 mcg on day 15 using the device clip (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 125 mcg IM starting on day 29, and every 14 days thereafter (Quantity: 2)	
Rebif® <input type="checkbox"/> Pre-filled Syringe Titration pack <input type="checkbox"/> Auto Injector Titration pack <input type="checkbox"/> Autoinjector <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Titration pack (Pre-filled Syringe only) <input type="checkbox"/> Autoinjector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: 44 mcg titration protocol Weeks 1-2: Inject 8.8 mcg SQ three times per week at least 48 hours apart (Quantity: 6) Weeks 3-4: Inject 22 mcg SQ three times per week at least 48 hours apart (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 44 mcg SQ three times per week at least 48 hours apart (Quantity: 12) <input type="checkbox"/> INITIAL: 22 mcg titration protocol Weeks 1-2: Inject 4.4 mcg SQ three times per week at least 48 hours apart (Quantity: 6) Weeks 3-4: Inject 11 mcg SQ three times per week at least 48 hours apart (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 22 mcg SQ three times per week at least 48 hours apart (Quantity: 12)	

MEDICAL INFORMATION

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY LAB NOTES REGARDING THERAPY		
PREVIOUS THERAPIES:	Tried & Failed (Duration):	Contraindication:
	/ / - / /	
	/ / - / /	
	/ / - / /	
Date of Diagnosis: / /	Number of relapses in the past year: _____	Is this patient nursing or planning pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> G35 Multiple Sclerosis <input type="checkbox"/> Other: _____	Date of last MRI: / /	Allergies:
Type: <input type="checkbox"/> Relapsing-remitting <input type="checkbox"/> Primary-progressive <input type="checkbox"/> Secondary-progressive <input type="checkbox"/> Progressive-relapsing	Were there any changes with the latest MRI? <input type="checkbox"/> Yes <input type="checkbox"/> No	

ADDITIONAL CLINICAL INFORMATION		
INJECTION TRAINING		
<input type="checkbox"/> Patient has received pen and injection training	<input type="checkbox"/> Physician's office to provide injection training	<input type="checkbox"/> Senderra to coordinate injection training

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

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.