Senderra Rx.
1301 E. Arapaho Rd., Ste.
101 Richardson, TX 75081
Main Tel: 888-777-5547
Fax: 888-777-5645
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RHEUMATOLOGY CAREPATH

PHYSICIAN:	**NPI:**
DEA:	
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

	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
DMARDS:			
☐ Methotrexate	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
NSAIDs:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Naproxen / Aleve	☐ (_____)	☐	_____
☐ Meloxicam	☐ (_____)	☐	_____
☐ Tramadol	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
SPECIALTY drugs:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Date of Diagnosis: ___/____/_____
- ☐ 714.0 Rheumatoid Arthritis
- ☐ 714.3 Juvenile Idiopathic Arthritis
- ☐ 696.0 Psoriatic Arthritis
- ☐ 720.0 Ankylosing Spondylitis
- ☐ Other: _____

Active TB is ruled out: ☐ **Yes** ☐ **No**
Hep B ruled out/treated: ☐ **Yes** ☐ **No**

Allergies:_____

_____

*****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:** _____

PRESCRIBER AND PRESCRIPTION INFORMATION

To be completed by prescriber
-or-
attach your prescription to the lower half of this form,
-or-
ePrescribe to
Senderra Rx
Richardson, TX 75081

Rx

COLCIGEL™ - 2 PAK
30mL (15mL x 2 Bottles) = 120 Doses | NDC-35781-0400-4

☐ Apply 1-4 pumps up to four times per day.

Circle desired refills : 1 2 3 other:___

Medically necessary for emergency flares.

Notes to Pharmacy	
Prescriber Name	
NPI#	Office Contact Name
Prescriber Phone	Prescriber FAX

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