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

Ancillary Immunology Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Telephone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐M ☐F	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Tel:	Alt. Tel:	☐ English ☐ Spanish ☐ Other:	Wt.: _____ Ht.: _____

PRESCRIPTION

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

Drug		Directions & Quantity	Refills
Methotrexate	☐ 2.5 mg tablet	☐ Take ___ tablet(s) PO every week (Quantity: 28-day supply)	
	☐ 25 mg/mL 2mL Inj Sol	☐ Inject ___ mL / ___mg SQ every 7 days the same day each week (Quantity: 28-day supply)	
Otrexup™	☐ 10 mg Auto Inj ☐ 12.5 mg Auto Inj ☐ 15 mg Auto Inj ☐ 17.5 mg Auto Inj ☐ 20 mg Auto Inj ☐ 22.5 mg Auto Inj ☐ 25 mg Auto Inj	Inject SQ every week (Quantity:4)	
Rasuvo™	☐ 7.5 mg Auto Inj ☐ 10 mg Auto Inj ☐ 12.5 mg Auto Inj ☐ 15 mg Auto Inj ☐ 17.5 mg Auto Inj ☐ 20 mg Auto Inj ☐ 22.5 mg Auto Inj ☐ 25 mg Auto Inj ☐ 27.5 mg Auto Inj ☐ 30 mg Auto Inj	Inject SQ every week (Quantity: 4)	

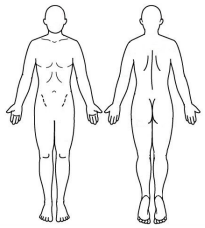
MEDICAL INFORMATION

*****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:**
☐ Methotrexate ☐ Oral ☐ SQ	☐ (_____)	☐	_____
☐ Rasuvo	☐ (_____)	☐	_____
☐ Otrexup	☐ (_____)	☐	_____
☐ Clobetasol	☐ (_____)	☐	_____
☐ Hydrocortisone	☐ (_____)	☐	_____
☐ Naproxen/Aleve	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

PHOTOTHERAPY	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ UVA /UVB	☐(_____)	☐	_____

☐Patient cannot afford ☐ Photosensitivity ☐Risk of Skin Cancer ☐ Distance from Office



☐Face ☐Feet ☐Groin ☐Hands
☐Nails ☐Scalp ☐Other:

Scoring tool used
☐BSA ☐EASI ☐ISGA ☐POEM
☐SCORAD ____% or Score: ____

- ☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
- ☐ M06.9 Rheumatoid Arthritis, Unspecified
- ☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
- ☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
- ☐ Other: _____

Date of Diagnosis: ____/____/_____

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

Allergies: _____

Additional Clinical Information:

American Academy of Dermatology Consensus Statement on Psoriasis Therapies

☐Psoriasis is covering greater than 10% of body surface area ☐ Psoriasis is on palms, soles, head and neck, or genitalia ☐ Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
☐Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships

INJECTION TRAINING

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

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: 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.

Prescribing Practitioner: **Date**: _____/_____/_____

CONFIDENTIALITY NOTICE