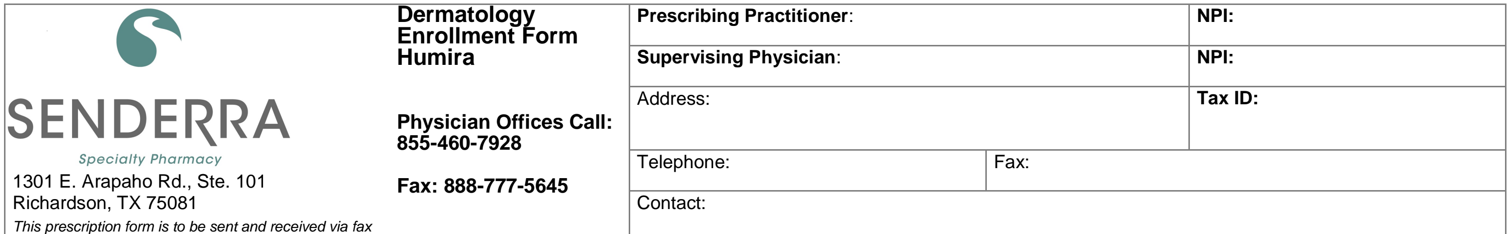
Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



SENDERRA Specialty Pharmacy
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent and received via fax

Dermatology Enrollment Form Humira

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: ____________________

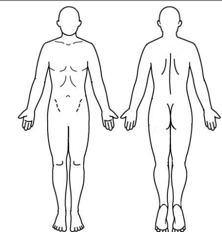
Drug		Directions & Quantity	Refills
Humira® *Citrate Free*	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 3) ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) (**Pre-filled Syringe only**) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4)	
	☐ Adolescent HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADOLESCENT:** ***WEIGHT REQUIRED*** ______ ☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4) *****Intended for weight ≥ 60 kg/132 lbs***** ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) *****Intended for weight 30 kg/66 lbs to <60 kg/132 lbs*****	
Humira®	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4)	
	☐ Adolescent HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADOLESCENT:** ***WEIGHT REQUIRED*** ______ ☐ **INITIAL:** Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4) *****Intended for weight ≥ 60 kg/132 lbs***** ☐ **INITIAL:** Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) *****Intended for weight 30 kg/66 lbs to <60 kg/132 lbs*****	

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	☐ (____________________)	☐	____________________
☐ Soriatane	☐ (____________________)	☐	____________________
☐ Clobetasol	☐ (____________________)	☐	____________________
☐ Hydrocortisone	☐ (____________________)	☐	____________________
☐ Calcipotriene	☐ (____________________)	☐	____________________
☐ Stelara	☐ (____________________)	☐	____________________
☐ Enbrel	☐ (____________________)	☐	____________________
☐ ____________________	☐ (____________________)	☐	____________________
☐ ____________________	☐ (____________________)	☐	____________________
PHOTOTHERAPY	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ UVA /UVB	☐(____________________)	☐	____________________

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



Affected Areas

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

Scoring tool used

☐ BSA ☐ISGA ______% or Score: ________

☐L40.0 Psoriasis Vulgaris (Plaque Psoriasis) ☐ L40.____ ________________________
☐L73.2 Hidradenitis suppurativa ☐ 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 to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: 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.

Prescribing Practitioner: **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.