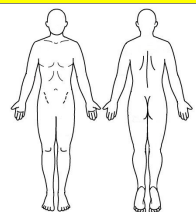
 <p>1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent and received via fax</i></p>	<b>Dermatology Enrollment Form I - Z</b>	<b>Prescribing Practitioner:</b>	<b>NPI:</b>	
	<b>Physician Offices Call: 855-460-7928</b>	<b>Supervising Physician:</b>	<b>NPI:</b>	
	<b>Fax: 888-777-5645</b>	<b>Address:</b>	<b>Tax ID:</b>	
		<b>Telephone:</b>	<b>Fax:</b>	
		<b>Contact:</b>		

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

PRESCRIPTION			
<input type="checkbox"/> New <input type="checkbox"/> Refill	Ship by: ____/____/____	SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____	
Drug	Directions & Quantity		Refills
<b>Ilumya™</b> <input type="checkbox"/> 100 mg Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 100 mg SQ at weeks 0 & 4 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 100 mg SQ every 12 weeks (Quantity: 1)		
<b>Otezla®</b> <input type="checkbox"/> 28 Day Starter Pack <input type="checkbox"/> Maintenance <input type="checkbox"/> Bridge Dose Pack	<input type="checkbox"/> Take as directed per package instructions (Quantity: 55) <input type="checkbox"/> 14 day titration starter pack sample provided by MD office <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 60) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 30) <b>Continuation of Therapy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 28) (12 refills) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 28) (6 refills)		
<b>Siliq™</b> <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 210 mg SQ on weeks 0 and 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)		
<b>Stelara®</b> <input type="checkbox"/> 45 mg Vial (Pediatric ≤ 60 kg) Pre-filled Syringe <input type="checkbox"/> 45 mg <input type="checkbox"/> 90 mg Weight Required: _____	<input type="checkbox"/> <b>INITIAL:</b> Inject SQ on day 0 and day 28 (Quantity: QS 2 doses) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject SQ every 12 weeks (Quantity: QS 1 dose)	<b>***WEIGHT BASED GUIDELINES:***</b> <b>PEDIATRIC:</b> Less than 60 kg (132.2 lbs): 0.75 mg/kg 60 kg-100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90mg <b>ADULT:</b> Less than or equal to 100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90mg	
<b>Taltz®</b> <input type="checkbox"/> Auto Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> <b>STARTING:</b> Inject 160 mg SQ on week 0 (Quantity: 2) <input type="checkbox"/> <b>INDUCTION:</b> Inject 80 mg SQ every 2 weeks (weeks 2-12) (Quantity: 2 plus 2 refills) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 80 mg SQ every 4 weeks (after 12 weeks) (Quantity: 1)		
<b>Tremfya®</b> <input type="checkbox"/> One-Press Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 100 mg SQ on week 0 and week 4 (Quantity: 1 plus 1 refill) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 100 mg SQ every 8 weeks (Quantity: 1)		

**MEDICAL INFORMATION**

**\*\*\*PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY\*\*\***

<b>PREVIOUS THERAPIES:</b>	<b>Tried &amp; Failed (Duration):</b>	<b>Not Tolerated:</b>	<b>Contraindication:</b>	
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	 <p><b>Affected Areas</b></p> <input type="checkbox"/> Face <input type="checkbox"/> Feet <input type="checkbox"/> Groin <input type="checkbox"/> Hands <input type="checkbox"/> Nails <input type="checkbox"/> Scalp <input type="checkbox"/> Other: <b>Scoring tool used</b> <input type="checkbox"/> BSA <input type="checkbox"/> EASI <input type="checkbox"/> ISGA <input type="checkbox"/> POEM <input type="checkbox"/> SCORAD _____% or Score: _____
<input type="checkbox"/> Soriatane	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Clobetasol	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Hydrocortisone	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Eucrisa	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Stelara	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Humira	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> _____	<input type="checkbox"/> (____)	<input type="checkbox"/>	_____	
<b>PHOTOTHERAPY</b>	<b>Tried &amp; Failed (Duration):</b>	<b>Not Tolerated:</b>	<b>Contraindication:</b>	
<input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford	<input type="checkbox"/> (____) <input type="checkbox"/> Photosensitivity	<input type="checkbox"/> <input type="checkbox"/> Risk of Skin Cancer	<input type="checkbox"/> Distance from Office	
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis)	<b>Date of Diagnosis:</b> ____/____/____			
<input type="checkbox"/> Other: _____				
Active TB is ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____		Hep B ruled out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> 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.