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 A - E

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

Has the patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/_____ ☐**No** | **SHIP TO:** ☐**Patient's Home** ☐**Doctor's Office** ☐**Other:**_____

Drug		Directions & Quantity	Refills
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ Inject 400 mg SQ (two 200 mg injections) every other week (Quantity: 4)	
Cosentyx™	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Cosentyx™ Covered Until You're Covered*	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
Dupixent®	☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 600 mg (two 300 mg injections in different sites) SQ on day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2) **ADOLESCENT:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 1 (Quantity: 2) ****(Less than 60 kg)**** ☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week starting at day 15 (Quantity: 2) **ADOLESCENT:** ***WEIGHT REQUIRED*** _____ ☐ **INITIAL:** Inject 600 mg (two 300 mg injections) SQ on day 1 (Quantity: 2) ****(Greater than or equal to 60 kg)**** ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2)	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐25 mg ☐50 mg ☐ Vials 25 mg	**ADULT:** ☐ **INITIAL**: Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) ☐ **MAINTENANCE**: Inject 50 mg SQ weekly (Quantity: 4) **PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ Inject ___ mg (0.8mg/kg x ___kg SQ every week) **(Less than or equal to 63 kg)** (Quantity: QS 1 month) ☐ Inject 50 mg SQ every week **(Greater than 63 kg)** (Quantity: 4)	

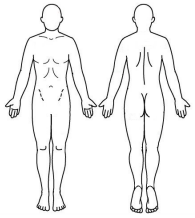
MEDICAL INFORMATION

*****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	☐ (_____)	☐	_____
☐ Soriatane	☐ (_____)	☐	_____
☐ Clobetasol	☐ (_____)	☐	_____
☐ Hydrocortisone	☐ (_____)	☐	_____
☐ Eucrisa	☐ (_____)	☐	_____
☐ Stelara	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ 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 ☐ EASI ☐ ISGA ☐ POEM
☐ SCORAD _____% or Score: _____

☐L20.9 Atopic Dermatitis (Moderate to Severe) ☐L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐L40.___ _____ ☐ 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