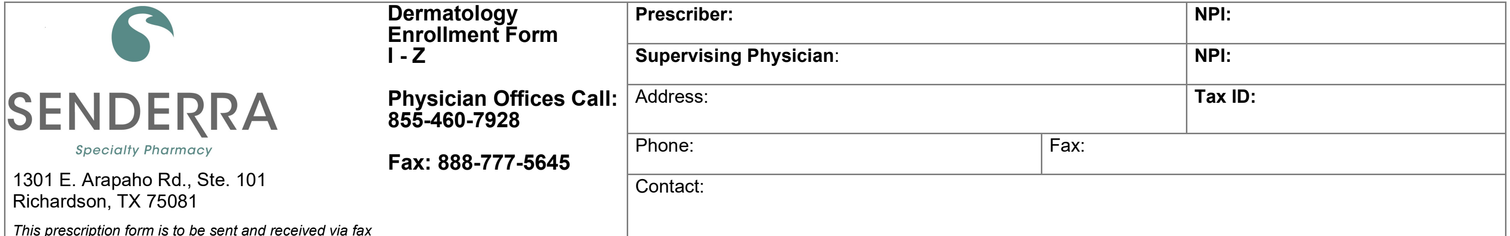
Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.



1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent and received via fax

Dermatology Enrollment Form I - Z

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescriber:	NPI:
Supervising Physician:	NPI:
Address:	Tax ID:
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/________	SS#: _____-_____-_________
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ 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
Ilumya ™	☐ Pre-filled Syringe	☐**INITIAL:** Inject 100 mg SQ at weeks 0 & 4 (Quantity: 2) ☐**MAINTENANCE:** Inject 100 mg SQ every 12 weeks (Quantity: 1)	
Otezla®	☐ 28 Day Starter Pack	☐ Take as directed per package instructions (Quantity: 55)	
	☐ Maintenance	☐ Take 30 mg PO twice daily (Quantity: 60)	
	☐ Bridge Dose Pack	☐ Take 30 mg PO twice daily (Quantity: 28) (12 refills)	
Siliq™	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 210 mg SQ at weeks 0 & 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)	
Skyrizi™	☐ Pre-filled Syringe	☐**INITIAL:** Inject 150 mg SQ at weeks 0 & 4 (Quantity: 2 plus 1 refill) ☐**MAINTENANCE:** Inject 150 mg SQ every 12 weeks (Quantity: 2)	
Stelara®	☐45 mg Vial (Ped. ≤ 60 kg) Pre-filled Syringe ☐45 mg ☐ 90 mg Weight Required: ________	☐**INITIAL:** Inject SQ at weeks 0 & 4 (Quantity: QS 2 doses) ☐**MAINTENANCE:** Inject SQ every 12 weeks (Quantity: QS 1 dose) ***WEIGHT BASED GUIDELINES*** PEDIATRIC: 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 ADULT: Less than or equal to 100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90mg	
Taltz®	☐ Auto Injector ☐ Pre-filled Syringe	☐ **STARTING:** Inject 160 mg (2 x 80 mg) SQ at week 0, then begin first induction dose 80 mg (1 x 80 mg) 2 weeks later (week 2) (Quantity: 3) ☐ **INDUCTION:** Inject 80 mg SQ every 2 weeks (weeks 4-10) (Quantity: 2 plus 1 refill) ☐ **FINAL INDUCTION:** Inject 80 mg SQ (week 12) (Quantity: 1) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1)	
	☐ 80 mg Auto Injector ☐ 80 mg Pre-filled Syringe	**PEDIATRIC:** ***WEIGHT REQUIRED*** ______ ☐ **STARTING:** Inject 160 mg (2 x 80 mg) SQ at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1) ***Intended for weight >50 kg/110 lbs***	
	☐ 80 mg Pre-filled Syringe	☐ **STARTING:** Inject 80 mg SQ at week 0 (Quantity: 1) ☐ **MAINTENANCE:** Inject 40 mg SQ every 4 weeks (thereafter) (Quantity: 1) ***Intended for weight 25 kg/55 lbs to 50 kg/110 lbs***	
		☐ **STARTING:** Inject 40 mg SQ at week 0 (Quantity: 1) ☐ **MAINTENANCE:** Inject 20 mg SQ every 4 weeks (thereafter) (Quantity: 1) ***Intended for weight <25 kg/55 lbs***	
Tremfya®	☐ One-Press Injector ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 100 mg SQ at week 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** 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*****

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (__________________)	☐	__________________
☐ Soriatane	☐ (__________________)	☐	__________________
☐ Clobetasol	☐ (__________________)	☐	__________________
☐ Stelara	☐ (__________________)	☐	__________________
☐ Humira	☐ (__________________)	☐	__________________
☐ Enbrel	☐ (__________________)	☐	__________________
☐ __________________	☐ (__________________)	☐	__________________

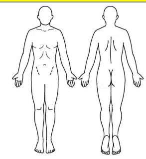
PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA /UVB	☐(__________________)	☐	__________________

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

☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis) ☐ Other: ______________________________

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

Additional Clinical Information:



Affected Areas

☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other:
BSA _______% PASI Score: ________

Date of Diagnosis: ____/____/______

Allergies:

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

PRESCRIBER SIGNATURE

To Prescriber 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.

Prescriber:	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.