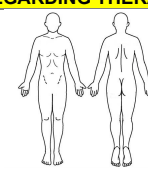
 <p><b>SENDERRA</b> Specialty Pharmacy 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent &amp; received via fax</i></p>	<p><b>Dermatology Enrollment Form A - E</b></p> <p><b>Physician Offices Call: 855-460-7928</b></p> <p><b>Fax: 888-777-5645</b></p>	<p><b>Prescriber:</b> _____</p> <p><b>Supervising Physician:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>Phone:</b> _____ <b>Fax:</b> _____</p> <p><b>Contact:</b> _____</p>	<p><b>NPI:</b> _____</p> <p><b>NPI:</b> _____</p> <p><b>Tax ID:</b> _____</p>
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PATIENT INFORMATION			
Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: ____/____/____	SS#: _____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION			
Has the patient received a loading dose/starter kit? <input type="checkbox"/> Yes Start Date: ____/____/____ <input type="checkbox"/> No SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____			
Drug	Directions & Quantity	Refills	
<b>Cimzia®</b> <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> Inject 400 mg SQ every other week (Quantity: 4)		
<b>Cosentyx™</b> <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every 4 weeks (Quantity: 2)		
<b>Cosentyx™ Covered Until You're Covered*</b> <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every 4 weeks (Quantity: 2)		
<b>Dupixent®</b> <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Pen	<b>ADULT:</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ on day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every other week starting at day 15 (Quantity: 2)		
	<b>PEDIATRIC: ***WEIGHT REQUIRED***</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ on day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every 4 weeks thereafter (Quantity: 2)		** (15 kg to less than 30 kg)**
	<b>PEDIATRIC: ***WEIGHT REQUIRED***</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 600 mg SQ on day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 300 mg SQ every other week starting at day 15 (Quantity: 2)		** (Greater than or equal to 60 kg)**
<input type="checkbox"/> Pre-filled Syringe	<b>PEDIATRIC: ***WEIGHT REQUIRED***</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 400 mg SQ on day 1 (Quantity: 2) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 200 mg SQ every other week starting at day 15 (Quantity: 2)		** (30 kg to less than 60 kg)**
<b>Enbrel®</b> <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini™ with AutoTouch™ <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Vials 25 mg	<b>ADULT:</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 50 mg SQ weekly (Quantity: 4)		
	<b>PEDIATRIC: ***WEIGHT REQUIRED***</b> <input type="checkbox"/> Inject ____ mg (0.8mg/kg x ____kg SQ every week) ( <b>Less than or equal to 63 kg</b> ) (Quantity: QS 1 month)		
	<input type="checkbox"/> Inject 50 mg SQ every week ( <b>Greater than 63 kg</b> ) (Quantity: 4)		

MEDICAL INFORMATION			
***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY***			
<b>PREVIOUS THERAPIES:</b> <input type="checkbox"/> Methotrexate <input type="checkbox"/> Soriatane <input type="checkbox"/> Clobetasol <input type="checkbox"/> Stelara <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> _____	<b>Tried &amp; Failed (Duration):</b> <input type="checkbox"/> (_____)	<b>Not Tolerated:</b> <input type="checkbox"/> _____	<b>Contraindication:</b> _____ _____ _____ _____
<b>PHOTOTHERAPY</b> <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford	<b>Tried &amp; Failed (Duration):</b> <input type="checkbox"/> (_____)	<b>Not Tolerated:</b> <input type="checkbox"/> _____	<b>Contraindication:</b> <input type="checkbox"/> Risk of Skin Cancer <input type="checkbox"/> Distance from Office
<input type="checkbox"/> L20.9 Atopic Dermatitis (Moderate to Severe) <input type="checkbox"/> L40.	<input type="checkbox"/> Photosensitivity	<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> Other: _____	 <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: _____
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: ____/____/____	<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: _____	
Allergies: _____ Additional Clinical Information: _____			

American Academy of Dermatology Consensus Statement on Psoriasis Therapies	
<input type="checkbox"/> Psoriasis is covering greater than 10% of body surface area <input type="checkbox"/> Psoriasis is on palms, soles, head and neck, or genitalia <input type="checkbox"/> Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints <input type="checkbox"/> Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships	
INJECTION TRAINING	
<input type="checkbox"/> Patient has received pen and injection training <input type="checkbox"/> Physician's office to provide injection training <input type="checkbox"/> 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. <b>Prescriber:</b> _____	<b>Date:</b> ____/____/____

**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.