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

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
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: QS 28 days) ☐ **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: QS 28 days) ☐ **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: QS 28 days) ☐ **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: QS 28 days) ☐ **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***	

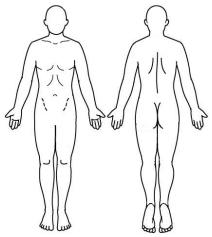
MEDICAL INFORMATION

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.