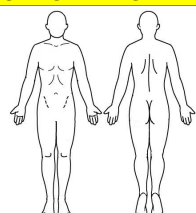
 <p>SENDERRA Specialty Pharmacy 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent and received via fax</i></p>	<p>Dermatology Enrollment Form A - E</p> <p>Physician Offices Call: 855-460-7928</p> <p>Fax: 888-777-5645</p>	<p>Prescribing Practitioner:</p> <p>Supervising Physician:</p> <p>Address: _____</p> <p>Telephone: _____ Fax: _____</p> <p>Contact: _____</p>	<p>NPI:</p> <p>NPI:</p> <p>Tax ID:</p>
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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	
Cimzia® <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> Inject 400 mg SQ (two 200 mg injections) every other week (Quantity: 4)		
Cosentyx™ <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: 2)		
Cosentyx™ Covered Until You're Covered <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: 2)		
Dupixent® <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 600 mg (two 300 mg injections in different sites) SQ on day 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every other week starting at day 15 (Quantity: 2)		
Enbrel® <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	ADULT: <input type="checkbox"/> INITIAL: Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) <input type="checkbox"/> MAINTENANCE: Inject 50 mg SQ weekly (Quantity: 4) PEDIATRIC: ***WEIGHT REQUIRED*** <input type="checkbox"/> Inject ____ mg (0.8mg/kg x ____kg SQ every week) (Less than or equal to 63 kg) (Quantity: ____ x 25 mg/mL) <input type="checkbox"/> 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:	 <p>Affected Areas</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: Scoring tool used <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"/> Methotrexate <input type="checkbox"/> Soriatane <input type="checkbox"/> Clobetasol <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Eucrisa <input type="checkbox"/> Stelara <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/>	<input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ _____ _____ _____ _____ _____ _____ _____ _____	
PHOTOTHERAPY <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford <input type="checkbox"/> Photosensitivity <input type="checkbox"/> Risk of Skin Cancer <input type="checkbox"/> Distance from Office	<input type="checkbox"/> (____) <input type="checkbox"/> (____)	<input type="checkbox"/> <input type="checkbox"/>	_____ _____ _____ _____	
<input type="checkbox"/> L20.9 Atopic Dermatitis (Moderate to Severe) <input type="checkbox"/> L40.____	<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> Other: _____			Date of Diagnosis: ____/____/____
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.