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 I - Z

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

☐ **New** ☐ **Refill** **Ship by:** ____/____/_____ **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug		Directions & Quantity	Refills
Ilumya™	☐ 100 mg 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) ☐ 14 day titration starter pack sample provided by MD office	
	☐ Maintenance	☐ Take 30 mg PO twice daily (Quantity: 60) ☐ Take 30 mg PO once daily (Quantity: 30) **Continuation of Therapy:** ☐ Yes ☐ No	
	☐ Bridge Dose Pack	☐ Take 30 mg PO twice daily (Quantity: 28) (12 refills) ☐ Take 30 mg PO once daily (Quantity: 28) (6 refills)	
Siliq™	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 210 mg SQ on weeks 0 and 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)	
Stelara®	☐ 45 mg Vial (Pediatric ≤ 60 kg) ☐ Pre-filled Syringe ☐ 45 mg ☐ 90 mg Weight Required: _____	☐ **INITIAL:** Inject SQ on day 0 and day 28 (Quantity: 2) ☐ **MAINTENANCE:** Inject SQ every 12 weeks (Quantity: 1) *****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 SQ on week 0 (Quantity: 2) ☐ **INDUCTION:** Inject 80 mg SQ every 2 weeks (weeks 2-12) (Quantity: 2 plus 2 refills) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (after 12 weeks) (Quantity: 1)	
Tremfya™	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 100 mg SQ on week 0 and week 4 (Quantity: 1 plus 1 refill) ☐ **MAINTENANCE:** Inject 100 mg SQ every 8 weeks (Quantity: 1)	

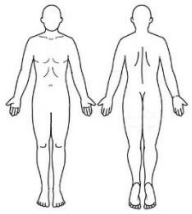
MEDICAL INFORMATION

*****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	☐ (_____)	☐	_____
☐ 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: _____

☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ 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