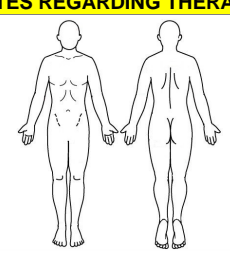
 <p>SENDERRA Specialty Pharmacy 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent and received via fax</i></p>	<p>Dermatology Enrollment Form Humira</p> <p>Physician Offices Call: 855-460-7928</p> <p>Fax: 888-777-5645</p>	<p>Prescribing Practitioner:</p> <p>Supervising 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	
Humira® Citrate Free <input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Adolescent HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)		
	ADULT: <input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every week (Quantity: 4)		
	ADOLESCENT: ***WEIGHT REQUIRED*** <input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every week (Quantity: 4) ***Intended for weight ≥ 60 kg/132 lbs*** <input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2) ***Intended for weight 30 kg/66 lbs to <60 kg/132 lbs***		
Humira® <input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Adolescent HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)		
	ADULT: <input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every week (Quantity: 4)		
	ADOLESCENT: ***WEIGHT REQUIRED*** <input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, 80 mg on day 15, then 40 mg once a week starting day 29 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every week (Quantity: 4) ***Intended for weight ≥ 60 kg/132 lbs*** <input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> 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:	
<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"/> 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"/>	_____ _____ _____ _____ _____ _____ _____	 <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: _____
PHOTOTHERAPY <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford	Tried & Failed (Duration): <input type="checkbox"/> (_____) _____ <input type="checkbox"/> Photosensitivity	Not Tolerated: <input type="checkbox"/> Risk of Skin Cancer	Contraindication: <input type="checkbox"/> Distance from Office	
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> L73.2 Hidradenitis suppurativa	<input type="checkbox"/> L40. _____ <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.