Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.

SENDERRA
Specialty Pharmacy

Psoriatic Arthritis Enrollment Form I - Z

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/________	SS#: ____-____-________	
Street:	City:	State:	ZIP:	
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: ________	Wt.: ________	Ht.: ________

PRESCRIPTION

Has patient received a loading dose/starter kit? ☐**Yes Start Date:** ____/____/_____ ☐**No** **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** ______________

Drug		Directions & Quantity	Refills
Orencia®	☐ 250 mg Vials ☐ Pre-filled Syringe ☐ ClickJect ™	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse ______ mg via IV at week 0, 2, and 4 (Quantity: QS 3 doses) ☐ **MAINTENANCE:** Infuse ______ mg via IV every 4 weeks (Quantity: QS 1 dose) **SUBCUTANEOUS (SQ):** ☐ Inject 125mg SQ once weekly (Quantity: 4)	
Otezla®	☐ 28 Day Starter Pack	☐ Take as directed per package instructions (Quantity: 55)	
	☐ Maintenance	☐ Take 30 mg PO twice daily (Quantity: 60)	
	☐ Bridge Dose Pack	☐ Take 30 mg PO twice daily (Quantity: 28) (12 refills)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month (Quantity: 1)	
Simponi Aria®	☐ 50 mg Vial Weight Required: ________	☐ **INITIAL:** Infuse 2 mg/kg via IV over 30 minutes at weeks 0 and 4 (Quantity: QS 2 doses) ☐ **MAINTENANCE:** Infuse 2 mg/kg via IV over 30 minutes every 8 weeks thereafter (Quantity: QS 1 dose)	
Stelara®	☐ Pre-filled Syringe Weight Required: ________	☐ **INITIAL:** Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 45 mg SQ every 12 weeks (Quantity: 1) ☐ **INITIAL:** Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 90 mg SQ every 12 weeks (Quantity: 1) *****WEIGHT BASED GUIDELINES***** **Less than or equal to 100 kg (220 lbs): 45 mg** **Greater than 100 kg (220 lbs): 90 mg**	
Taltz®	☐ Auto Injector ☐ Pre-filled Syringe	☐**INITIAL:** Inject 160 mg (2 x 80 mg) SQ at week 0 (Quantity: 2) ☐**MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1) ☐**STARTING:** Inject 160 mg (2 x 80 mg) SQ at week 0, then begin first induction dose 80 mg (1 x 80 mg) 2 weeks later (week 2) (Quantity: 3) ☐**INDUCTION:** Inject 80 mg SQ every 2 weeks (weeks 4-10) (Quantity: 2 plus 1 refill) ☐**FINAL INDUCTION:** Inject 80 mg SQ (week 12) (Quantity: 1) ☐**MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1)	
Tremfya®	☐ One-Press Injector ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 100 mg SQ at week 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 100 mg SQ every 8 weeks (Quantity: 1)	
Xeljanz®	5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)	

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	☐ (____________________)	☐	____________________
☐ Sulfasalazine	☐ (____________________)	☐	____________________
☐ Naproxen / Aleve	☐ (____________________)	☐	____________________
☐ Enbrel	☐ (____________________)	☐	____________________
☐ Humira	☐ (____________________)	☐	____________________
☐ Cimzia	☐ (____________________)	☐	____________________
☐ ____________________	☐ (____________________)	☐	____________________
☐ ____________________	☐ (____________________)	☐	____________________

☐ L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis) ☐ L40.52 Psoriatic Arthritis Mutilans
☐ L40.59 Other Psoriatic Arthropathy ☐ Other: ______________________________

Date of Diagnosis: _____/_____/__________ Allergies: ______________________________

Active TB is ruled out: ☐Yes ☐No Date: ____/____/____ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/____

Additional Clinical Information:

INJECTION TRAINING

☐Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ 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.

Prescriber: **Date**: ________/________/____________

CONFIDENTIALITY NOTICE