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 & received via fax

Psoriatic Arthritis Enrollment Form
I - Z

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Office:	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
Orencia®	☐ Pre-filled Syringe ☐ Vials ☐ ClickJect ™	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV on week 0, 2, and 4(Quantity: ___) ☐ **MAINTENANCE:** Infuse _____ mg via IV every 4 weeks (Quantity: ___) **SUBCUTANEOUS (SQ):** ☐ Inject 125mg SQ once weekly (Quantity: 4)	
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)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month (Quantity: 1)	
Stelara®	☐ Pre-filled Syringe Weight Required: _____	☐ **INITIAL:** Inject 45 mg SQ on Day 0 & Day 28 (Quantity: 2) ☐ **MAINTENANCE:** Inject 45 mg SQ every 12 weeks (Quantity: 1) ☐ **INITIAL:** Inject 90 mg SQ on Day 0 & Day 28 (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 SQ on week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (Quantity: 1) ☐ **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)	
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	☐ (_____)	☐	_____
☐ Plaquenil	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Meloxicam	☐ (_____)	☐	_____
☐ 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

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