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
Main Tel: 888-777-5547
Fax: 888-777-5645

Dermatology Enrollment

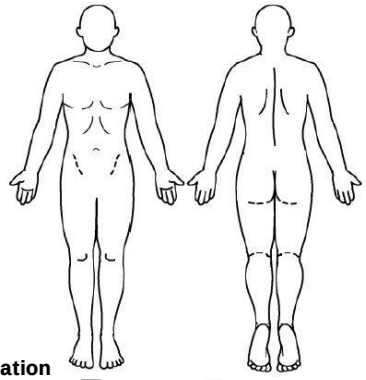
Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	
Office:	Fax:
Contact:	

PATIENT INFORMATION

Name:		☐ M ☐ F	DOB: ____/____/____	SS#: ____-____-____
Tel:	Al. Tel:	☐ English ☐ Spanish ☐ Other: _____		Wt.: _____ Ht.: _____
Street:	City:	State:	ZIP:	

MEDICAL INFORMATION

	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
DMARDS:			
☐ Methotrexate	☐ (_____)	☐	_____
☐ Soriatane	☐ (_____)	☐	_____
☐ Cyclosporine	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
TOPICAL Agents	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Clobetasol	☐ (_____)	☐	_____
☐ Hydrocortisone	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
PHOTOTHERAPY	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ UVA /UVB	☐ (_____)	☐	_____
☐ Patient cannot afford ☐ Photosensitivity		☐ Risk of Skin Cancer	☐ Distance from Office
Specialty Drugs:	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ Humira	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____



Location
☐ Hands ☐ Feet ☐ Scalp
☐ Groin ☐ Nails ☐ Face
☐ Other:

BSA (% is **required**): _____%

Allergies:

Date of Diagnosis: ____/____/_____
☐ L40.0 Psoriasis Vulgaris
☐ L40.5 Psoriatic Arthritis (Include failed NSAIDs:_____)
☐ L73.2 Hidradenitis suppurativa
☐ Other:

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

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY*****

PRESCRIPTION

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

Drug		Directions & Quantity	Refills
Enbrel®	☐ SureClick Pen 50 mg ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	☐ **Psoriasis Initial**: Inject 50 mg twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) ☐ **Psoriasis Maintenance**: Inject 50 mg weekly (Quantity: 4) ☐ Inject 50 mg SQ twice weekly 72-96 hours apart (Quantity: 8) ☐ Inject 50 mg SQ every week (Quantity: 4) ☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8)	
Humira®	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe ☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ☐ **INITIAL:** Inject 160 mg SQ on Day 1, then 80mg on Day 15 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4)	
Otezla®	☐ Titration Starter Pack ☐ Maintenance ☐ Bridge Dose Pack	☐ Take as directed (Quantity: 55) **These directions can only be selected for the Titration Starter Pack** ☐ Take 30 mg PO twice daily (Quantity: 60) ☐ Take 30 mg PO once daily (Quantity: 30) ☐ 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 monthly (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 must be greater than 220lbs ****	
Cosentyx(™)	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: 2)	
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)	

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 Rx to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Senderra Rx 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

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