

Alopecia Areata Enrollment Form
Physician Offices Call: 855-460-7928
Fax: 888-777-5645

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

PATIENT INFORMATION

Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: ____/____/____	SS#: ____-____-____
Street:	City:	State:	ZIP: ____-____-____
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: _____ Ht.: _____

PRESCRIPTION

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

Drug	Directions & Quantity	Refills
Leqselvi™ 8 mg Tablet	<input type="checkbox"/> Take 8 mg PO twice daily (Quantity: 60)	
Litfulo® 50 mg Capsule	<input type="checkbox"/> Take 50 mg PO once daily (Quantity: 28)	
Olumiant®	<input type="checkbox"/> 2 mg Tablet <input type="checkbox"/> Take 2 mg PO once daily (Quantity: 30)	
	<input type="checkbox"/> 4 mg Tablet <input type="checkbox"/> Take 4 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*****

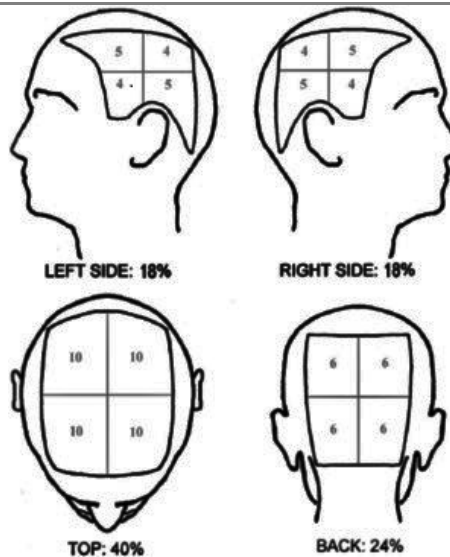
Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:	Allergies:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Prednisone	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	

Date of Diagnosis: ____/____/____

L63.9 Alopecia areata, unspecified Other: _____

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

Additional Clinical Information:



SALT Score: _____

Affected Areas:

Scalp % of hair loss _____

Non-scalp (specify below)

Face % of hair loss _____

Nails % affected _____

Other: _____ % of hair loss _____

AA Scale

Mild AA (20% or less scalp hair loss)

Moderate AA (21%-49% scalp hair loss)

Severe AA (50%-100% scalp hair loss)

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

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