



**SENDERRA**  
Specialty Pharmacy  
3712 E. Plano Parkway, Ste. 200  
Plano, TX 75074  
*This prescription form is to be sent & received via fax*

**Ancillary Dermatology 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**

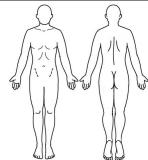
Has the patient received a loading dose/starter kit?  Yes Start Date: / /  No SHIP TO:  Patient's Home  Doctor's Office  Other: \_\_\_\_\_

Drug	Strength	Quantity	Drug	Strength	Quantity
<input type="checkbox"/> Aczone (dapsones)	<input type="checkbox"/> 5% Gel 60 gm <input type="checkbox"/> 7.5% Gel 60 gm		<input type="checkbox"/> Mirvaso (brimonidine)	0.33% Gel 30 gm	
<input type="checkbox"/> BenzaClin (clindamycin & BPO)	<input type="checkbox"/> 1-5 % Gel 25 gm <input type="checkbox"/> 1-5% Gel 35 gm <input type="checkbox"/> 1-5% Gel 50 gm		<input type="checkbox"/> Opzelura	<input type="checkbox"/> 1.5% Cream 60 gm <input type="checkbox"/> 1.5% Cream 100 gm	
<input type="checkbox"/> Cabtreo	1.2%/0.15%/3.1% Gel 50 gm		<input type="checkbox"/> Oracea (doxycycline)	40 mg Capsules	30
<input type="checkbox"/> Clobetazol	<input type="checkbox"/> 0.05% Cream 60 gm <input type="checkbox"/> 0.05% Lotion 59 mL		<input type="checkbox"/> Protopic (tacrolimus)	0.03% Ointment 60 gm	
<input type="checkbox"/> Desonate (desonide)	<input type="checkbox"/> 0.05% Gel 60 gm <input type="checkbox"/> 0.05% Cream 60 gm		<input type="checkbox"/> Retin-A Micro	<input type="checkbox"/> 0.06% Pump Gel 50 gm <input type="checkbox"/> 0.08% Pump Gel 50 gm	
<input type="checkbox"/> Duobrii	0.01%-0.045% Lotion 100 gm		<input type="checkbox"/> Rhofade	1% Cream 30 gm	
<input type="checkbox"/> Efudex (fluorouracil)	5% Cream 40 gm		<input type="checkbox"/> Seysara	<input type="checkbox"/> 60 mg Tablet <input type="checkbox"/> 100 mg Tablet <input type="checkbox"/> 150 mg Tablet	30
<input type="checkbox"/> Elidel (pimecrolimus)	1% Cream 60 gm		<input type="checkbox"/> Soolantra (ivermectin)	1% Cream 45 gm	
<input type="checkbox"/> Enstilar	<input type="checkbox"/> 0.005%-0.064% Foam 60 gm <input type="checkbox"/> 0.050%-0.064% Foam 120 gm		<input type="checkbox"/> Tavorole	5% Topical Solution 10 mL	
<input type="checkbox"/> Epiduo (adapalene & BPO)	0.1%-2.5% Gel 45 gm		<input type="checkbox"/> Tazorac (tazarotene)	0.1% Cream 60 gm	
<input type="checkbox"/> Epiduo Forte	0.3%-2.5% Gel 45 gm		<input type="checkbox"/> Triamcinolone Acetonide	0.1% Lotion 60 mL	
<input type="checkbox"/> Eucrisa	2% Ointment 60 gm		<input type="checkbox"/> Ultravate (halbetasol propionate)	0.05% Lotion 60 mL	
<input type="checkbox"/> Finacea (azelaic acid)	<input type="checkbox"/> 15% Gel 50 gm <input type="checkbox"/> 15% Foam 50 gm		<input type="checkbox"/> Vanos (fluocinonide)	0.1% Cream 60 gm	
<input type="checkbox"/> Halog (halocinonide)	<input type="checkbox"/> 0.1% Ointment 60 gm <input type="checkbox"/> 0.1% Cream 60 gm		<input type="checkbox"/> Veltin (clindamycin/tretinoin)	1.2/0.025% Gel 30 gm	
<input type="checkbox"/> Hydrocortisone Butyrate	0.1% Cream 60 gm		<input type="checkbox"/> Vtama	1% Cream 60 gm	
<input type="checkbox"/> Jublia	10% Solution 4mL		<input type="checkbox"/> Winlevi	1% Cream 60 gm	
<input type="checkbox"/> Ketoconazole	<input type="checkbox"/> 2% Cream 30 gm <input type="checkbox"/> 2% Cream 60 gm		<input type="checkbox"/> Zoryve	<input type="checkbox"/> 0.3% Cream 60 gm <input type="checkbox"/> 0.15% Cream 60 gm <input type="checkbox"/> 0.05% Cream 60 gm <input type="checkbox"/> 0.3% Foam 60 gm	

Directions: \_\_\_\_\_ Refills: \_\_\_\_\_

**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:	 <p><b>Affected Areas</b></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: _____ BSA %: _____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
Diagnosis (description): _____		ICD-10 Code(s): _____		
Date of Diagnosis: / /		Allergies: _____		
Additional Clinical Information: _____				

**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.

**PRODUCT SUBSTITUTION PERMITTED**  **DISPENSE AS WRITTEN**

X \_\_\_\_\_ Date: / / X \_\_\_\_\_ Date: / /

**CONFIDENTIALITY NOTICE**

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