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

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

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:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ 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
Aczone (dapsone)	☐ 5% Gel 60 gm ☐ 7.5% Gel 60 gm	**Ketoconazole**	☐ 2% Cream 30 gm ☐ 2% Cream 60 gm
BenzaClin (clindamycin & BPO)	☐ 1-5 % Gel 25 gm ☐ 1-5% Gel 35 gm ☐ 1-5% Gel 50 gm	☐ **Kerydin** (tavaborole)	5% Topical Solution 10 mL
Clobetasol	☐ 0.05% Cream 60 gm ☐ 0.05% Lotion 59 mL	☐ **Mirvaso**	0.33% Gel 30 gm
Cordran (flurandrenolide)	☐ 0.05% Ointment 60 gm ☐ 0.05% Cream 120 gm	**Naftin** (Naftifine HCL)	☐ 2% Cream 45 gm ☐ 2 % Gel 60 gm
Desonate (desonide)	☐ 0.05% Gel 60 gm ☐ 0.05% Cream 60 gm	☐ **Onexton**	Gel 50 gm
☐ **Doxepin HCL**	5% Cream 45 gm	☐ **Oracea** (doxycycline)	40 mg Capsules (Quantity: 30)
☐ **Duobrii**	0.01%-0.045% Lotion 100 gm	☐ **Protopic** (tacrolimus)	0.03% Ointment 60 gm
☐ **Efudex** (fluorouracil)	5% Cream 40 gm	**Retin-A Micro**	☐ 0.06% Pump Gel 50 gm ☐ 0.08% Pump Gel 50 gm
☐ **Eletone**	Cream 100 gm	☐ **Rhofade**	1% Cream 30 gm
☐ **Elidel** (pimecrolimus)	1% Cream 60 gm	☐ **Soolantra** (ivermectin)	1% Cream 45 gm
Enstilar	☐ 0.005%-0.064% Foam 60 gm ☐ 0.050%-0.064% Foam 120 gm	☐ **Tazorac** (tazarotene)	0.1% Cream 60 gm
☐ **Epiduo** (adapalene & BPO)	0.1%-2.5% Gel 45 gm	☐ **Tolak**	4% Cream 40 gm
☐ **Epiduo Forte**	0.3%-2.5% Gel 45 gm	☐ **Triamcinolone Acetonide**	0.1% Lotion 60 mL
☐ **Eucrisa**	2% Ointment 60 gm	☐ **Ultravate** (halbetasol propionate)	0.05% Lotion 60 mL
Finacea (azelaic acid)	☐ 15% Gel 50 gm ☐ 15% Foam 50 gm	☐ **Vanos** (fluocinonide)	0.1% Cream 60 gm
Halog (halocinonide)	☐ 0.1% Ointment 60 gm ☐ 0.1% Cream 60 gm	☐ **Veltin** (clindamycin/tretinoin)	1.2/0.025% Gel 30 gm
☐ **Hydrocortisone Butyrate**	0.1% Cream 60 gm	☐ **Vtama**	1% Cream 60 gm
☐ **Jublia**	10% Solution 4mL	☐ **Zoryve**	0.3% Cream 60 gm

Directions: | **Refills**

MEDICAL INFORMATION

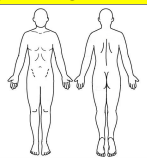
PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Diagnosis (description): _____ **ICD-10 Code(s):** _____

Date of Diagnosis: _____/_____/_____ **Allergies:** _____

Additional Clinical Information:



Affected Areas

☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other: BSA %: ___

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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