



3712 E. Plano Parkway, Ste. 200
Plano, TX 75074

This prescription form is to be sent & received via fax

Ancillary Immunology 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

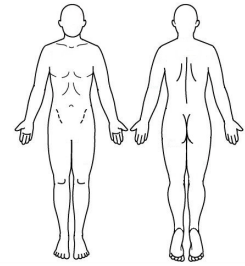
Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: ____/____/____	SS#: ____-____-____
Street:	City:	State:	ZIP: ____-____-____
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/>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

PRESCRIPTION

<input type="checkbox"/> New <input type="checkbox"/> Refill	Ship by: ____/____/____	SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____
Drug	Directions & Quantity	Refills
Methotrexate	<input type="checkbox"/> 2.5 mg tablet <input type="checkbox"/> 25 mg/mL 2mL Inj Sol <input type="checkbox"/> Take ____ tablet(s) PO every week (Quantity: 28-day supply) <input type="checkbox"/> Inject ____ mL / ____ mg SQ every 7 days the same day each week (Quantity: 28-day supply)	
Rasuvo®	<input type="checkbox"/> 7.5 mg Auto Inj <input type="checkbox"/> 10 mg Auto Inj <input type="checkbox"/> 12.5 mg Auto Inj <input type="checkbox"/> 15 mg Auto Inj <input type="checkbox"/> 17.5 mg Auto Inj <input type="checkbox"/> 20 mg Auto Inj <input type="checkbox"/> 22.5 mg Auto Inj <input type="checkbox"/> 25 mg Auto Inj <input type="checkbox"/> 27.5 mg Auto Inj <input type="checkbox"/> 30 mg Auto Inj Inject SQ every week (Quantity: 4)	

MEDICAL INFORMATION

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

PREVIOUS THERAPIES: <input type="checkbox"/> Methotrexate <input type="checkbox"/> Oral <input type="checkbox"/> SQ <input type="checkbox"/> Rasuvo <input type="checkbox"/> Otrexup <input type="checkbox"/> Clobetasol <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Naproxen/Aleve <input type="checkbox"/> _____ <input type="checkbox"/> _____	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/>	Contraindication: _____ _____ _____ _____ _____ _____ _____	 <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: Scoring tool used <input type="checkbox"/> BSA <input type="checkbox"/> EASI <input type="checkbox"/> IGA <input type="checkbox"/> POEM <input type="checkbox"/> SCORAD ____ % or Score: ____
PHOTOTHERAPY <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/>	Contraindication: <input type="checkbox"/> Distance from Office	
<input type="checkbox"/> M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified <input type="checkbox"/> M06.9 Rheumatoid Arthritis, Unspecified <input type="checkbox"/> M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified <input type="checkbox"/> M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site <input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> Other: _____				Date of Diagnosis: ____/____/____

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

Allergies: _____

Additional Clinical Information:

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 to coordinate injection training

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

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.