



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

This prescription form is to be sent & received via fax

Ankylosing Spondylitis 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
Bimzelx®	<input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Autoinjector	Inject 160 mg SQ every 4 weeks (Quantity: 1)	
Cimzia®	<input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Inject 400 mg SQ at weeks 0, 2, & 4 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 400 mg SQ every 4 weeks (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every other week (Quantity: 2)	
Cosentyx®	<input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg SQ at week 0, 1, 2, 3, & 4 (Quantity: 5) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1)	***Dosing intended for adults & pediatrics ≥ 50 kg/110 lbs with Ankylosing Spondylitis or adults with Non-Radiographic Axial Spondyloarthritis***
	<input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> UnoReady® Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days)	***Dosing intended for adults with Ankylosing Spondylitis who continue to have active Ankylosing Spondylitis***
	<input type="checkbox"/> Pre-filled Syringe	PEDIATRICS: <input type="checkbox"/> INITIAL: Inject 75 mg SQ at week 0, 1, 2, 3, & 4 (Quantity: 5) <input type="checkbox"/> MAINTENANCE: Inject 75 mg SQ every 4 weeks	***Dosing intended for pediatrics < 50 kg/110 lbs with Ankylosing Spondylitis***
Enbrel®	<input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini® with AutoTouch® <input type="checkbox"/> 50 mg Pre-filled Syringe	<input type="checkbox"/> Inject 50 mg SQ every week (Quantity: 4)	
Humira® Citrate Free	<input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2)	
Rinvoq®	15 mg Tablets	<input type="checkbox"/> Take 15 mg PO once daily (Quantity: 30)	
Simponi®	<input type="checkbox"/> SmartJect® Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Inject 50 mg SQ once a month (Quantity: 1)	
Taltz®	<input type="checkbox"/> Autoinjector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SQ at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every 4 weeks (Quantity: 1) <input type="checkbox"/> Inject 80 mg SQ every 4 weeks (Quantity: 1) ***Dosing intended for Non-Radiographic Axial Spondyloarthritis (Nr-axSpA)***	
Xeljanz®	5 mg Tablets	<input type="checkbox"/> Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	11 mg Tablets	<input type="checkbox"/> Take 11 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:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____

<input type="checkbox"/> M45.9 Ankylosing Spondylitis, Unspecified	<input type="checkbox"/> M45._____
<input type="checkbox"/> M45.A0 Non-Radiographic Axial Spondyloarthritis (Nr-axSpA) of unspecified sites in spine	<input type="checkbox"/> M45.A_____
<input type="checkbox"/> M46.8 _____	<input type="checkbox"/> Other: _____

Date of Diagnosis: / / Allergies: _____

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

HLA-B27 Positive: Yes No Date: / /

Additional Clinical Information:

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

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