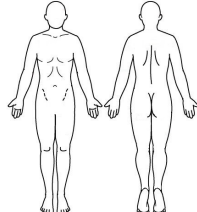
 SENDERRA <small>Specialty Pharmacy</small> 3712 E. Plano Parkway, Ste. 200 Plano, TX 75074 <small>This prescription form is to be sent & received via fax</small>	Dermatology Injectable Enrollment Form E-L		Prescriber:		NPI:	
	Physician Offices Call: 855-460-7928		Supervising Physician:		NPI:	
	Fax: 888-777-5645		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: ____/____/____	
Street:		City:		State: ____ - ____	
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? <input type="checkbox"/> Yes Start Date: ____/____/____ <input type="checkbox"/> No SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____			
Drug	Directions & Quantity	Refills	
Enbrel® <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini® with AutoTouch® <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) <input type="checkbox"/> MAINTENANCE: Inject 50 mg SQ weekly (Quantity: 4)		
Humira® Citrate Free <input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week (Quantity: QS 28 days) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)		
Ilumya® <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 100 mg SQ at weeks 0 & 4 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 12 weeks (Quantity: 1)		

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"/> Soriatane <input type="checkbox"/> Clobetasol <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> _____	Tried & Failed (Duration): <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Contraindication: _____ _____ _____ _____ _____ _____	 Affected Areas <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: <input type="checkbox"/> BSA ____ % PASI Score: ____
PHOTOTHERAPY <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford <input type="checkbox"/> Photosensitivity <input type="checkbox"/> Risk of Skin Cancer <input type="checkbox"/> Distance from Office	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/>	Contraindication: _____	Allergies: _____ _____ _____
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> Other: _____				
Date of Diagnosis: ____/____/____				

Active TB is ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____		Hep B ruled out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____	
Additional Clinical Information:			

American Academy of Dermatology Consensus Statement on Psoriasis Therapies	
<input type="checkbox"/> Psoriasis is covering greater than 10% of body surface area <input type="checkbox"/> Psoriasis is on palms, soles, head and neck, or genitalia <input type="checkbox"/> Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints <input type="checkbox"/> Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships	
INJECTION TRAINING	
<input type="checkbox"/> Patient has received pen and injection training <input type="checkbox"/> Physician's office to provide injection training <input type="checkbox"/> 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.	