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

**Dermatology Injectable Enrollment Form A-D**

**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:** _____

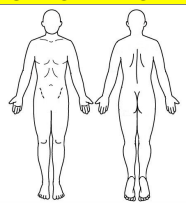
| Drug | | Directions & Quantity | Refills |
|---|---|---|---|
| **Bimzelx®** | ☐ Pre-filled Syringe<br>☐ Autoinjector | ☐ **INITIAL:** Inject 320 mg SQ on week 0, 4, 8, 12, and 16 (Quantity: 5)<br>☐ **MAINTENANCE:** Inject 320 mg SQ every 8 weeks (Quantity: 1)<br>☐ **MAINTENANCE:** Inject 320 mg SQ every 4 weeks (Quantity: 1) ***Intended for patients ≥ 120 kg (264 lbs)*** | |
| **Cimzia®** | ☐ Pre-filled Syringe<br>☐ Vials | ☐ Inject 400 mg SQ every other week (Quantity: 4)<br>☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on week 0, 2, 4 (Quantity: 6)<br>☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week starting on week 6 (Quantity: 2) ***Intended for patients ≤ 90 kg (198 lbs)*** | |
| **Cosentyx®** | ☐ Sensoready® Pen<br>☐ Pre-filled Syringe | ☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5)<br>☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) | |
| | ☐ Sensoready® Pen<br>☐ UnoReady® Pen<br>☐ Pre-filled Syringe | ☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: QS 5 doses)<br>☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days) | |
| **Dupixent®** | ☐ Pen<br>☐ Pre-filled Syringe | ☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2) | |

## 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: |
|---|---|---|---|
| ☐ Methotrexate | ☐ (_____) | ☐ | _____ |
| ☐ Soriatane | ☐ (_____) | ☐ | _____ |
| ☐ Clobetasol | ☐ (_____) | ☐ | _____ |
| ☐ Humira | ☐ (_____) | ☐ | _____ |
| ☐ Enbrel | ☐ (_____) | ☐ | _____ |
| ☐ _____ | ☐ (_____) | ☐ | _____ |

| PHOTOTHERAPY | Tried & Failed (Duration): | Not Tolerated: | Contraindication: |
|---|---|---|---|
| ☐ UVA /UVB | ☐ (_____) | ☐ | _____ |
| ☐ Patient cannot afford | ☐ Photosensitivity | ☐ Risk of Skin Cancer | ☐ Distance from Office |



**Affected Areas**

☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other: _____
BSA ____% PASI Score ____

**Allergies:**

☐ L12.0 Bullous Pemphigoid
☐ L28.1 Prurigo Nodularis
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ L50.8 Other Urticaria
☐ Other: _____

**Date of Diagnosis**: ____/____/_____

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

**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