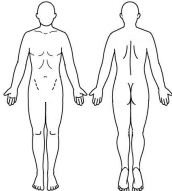
 <p>SENDERRA Specialty Pharmacy</p> <p>3712 E. Plano Parkway, Ste. 200 Plano, TX 75074</p> <p><i>This prescription form is to be sent & received via fax</i></p>	<p>Dermatology Injectable Enrollment Form M - Z</p> <p>Physician Offices Call: 855-460-7928</p> <p>Fax: 888-777-5645</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">Prescriber:</td> <td>NPI:</td> </tr> <tr> <td colspan="2">Supervising Physician:</td> <td>NPI:</td> </tr> <tr> <td colspan="2">Address:</td> <td>Tax ID:</td> </tr> <tr> <td>Phone:</td> <td colspan="2">Fax:</td> </tr> <tr> <td colspan="3">Contact:</td> </tr> </table>		Prescriber:		NPI:	Supervising Physician:		NPI:	Address:		Tax ID:	Phone:	Fax:		Contact:		
	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? <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
Nemluvio™	<input type="checkbox"/> Pen	<input type="checkbox"/> INITIAL: Inject 60 mg (2 x 30 mg) SQ at week 0 (Quantity: 2)	***WEIGHT REQUIRED***		
		<input type="checkbox"/> MAINTENANCE: Inject 30 mg SQ every 4 weeks (Quantity: 1)	***Intended for weight < 90 kg/198 lbs***		
		<input type="checkbox"/> MAINTENANCE: Inject 60 mg (2 x 30 mg) SQ every 4 weeks (Quantity: 2)	***Intended for weight ≥ 90 kg/198 lbs***		
Siliq®	<input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 210 mg SQ at weeks 0 & 1 (Quantity: 2)			
		<input type="checkbox"/> MAINTENANCE: Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)			
Skyrizi®	<input type="checkbox"/> Pen	<input type="checkbox"/> INITIAL: Inject 150 mg SQ at weeks 0 & 4 (Quantity: 1 plus 1 refill)			
	<input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 12 weeks (Quantity: 1)			
Stelara®	<input type="checkbox"/> 45 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2)	***WEIGHT REQUIRED***		
		<input type="checkbox"/> MAINTENANCE: Inject 45 mg SQ every 12 weeks (Quantity: 1)	***Intended for weight ≤ 100 kg/220 lbs***		
	<input type="checkbox"/> 90 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2)	***Intended for weight > 100 kg/220 lbs***		
		<input type="checkbox"/> MAINTENANCE: Inject 90 mg SQ every 12 weeks (Quantity: 1)			
Taltz®	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> STARTING: Inject 160 mg (2 x 80 mg) SQ at week 0, then begin first induction dose 80 mg (1 x 80 mg) 2 weeks later (week 2) (Quantity: 3)			
		<input type="checkbox"/> INDUCTION: Inject 80 mg SQ every 2 weeks (weeks 4-10) (Quantity: 2 plus 1 refill)			
		<input type="checkbox"/> FINAL INDUCTION: Inject 80 mg SQ (week 12) (Quantity: 1)			
		<input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1)			
Tremfya®	<input type="checkbox"/> One-Press Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 100 mg SQ at week 0 & 4 (Quantity: 2)			
		<input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 8 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:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:	 <p>Affected Areas</p> <p> <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: </p> <p>BSA % PASI Score:</p>	
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> ()	<input type="checkbox"/>			
<input type="checkbox"/> Soriatane	<input type="checkbox"/> ()	<input type="checkbox"/>			
<input type="checkbox"/> Clobetasol	<input type="checkbox"/> ()	<input type="checkbox"/>			
<input type="checkbox"/> Stelara	<input type="checkbox"/> ()	<input type="checkbox"/>			
<input type="checkbox"/> Humira	<input type="checkbox"/> ()	<input type="checkbox"/>			
<input type="checkbox"/> Enbrel	<input type="checkbox"/> ()	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/> ()	<input type="checkbox"/>			
PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:		
<input type="checkbox"/> UVA /UVB	<input type="checkbox"/> ()	<input type="checkbox"/>			
<input type="checkbox"/> Patient cannot afford	<input type="checkbox"/> Photosensitivity	<input type="checkbox"/> Risk of Skin Cancer	<input type="checkbox"/> Distance from Office		
<input type="checkbox"/> L28.1 Prurigo Nodularis		<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis)			
<input type="checkbox"/> Other:					
Active TB 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.					