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 Oral/Topical 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:	☐ 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:**_____

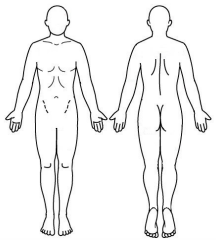
Drug		Directions & Quantity	Refills
Leqselvi™	8 mg Tablet	☐ Take 8 mg PO twice daily (Quantity: 60)	
Litfulo®	50 mg Capsule	☐ Take 50 mg PO once daily (Quantity: 28)	
Olumiant®	☐2 mg Tablet	☐ Take 2 mg PO once daily (Quantity: 30)	
	☐4 mg Tablet	☐ Take 4 mg PO once daily (Quantity: 30)	
Opzelura®	1.5 % Cream 60 gm	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Otezla®	☐ 28 Day Starter Pack	☐ Take as directed per package instructions (Quantity: 55)	
	☐ 30 mg Tablet	☐ Take 30 mg PO twice daily (Quantity: 60)	
Sotyktu™	6 mg Tablet	☐ Take 6 mg PO once daily (Quantity: 30)	
Vtama®	1% Cream 60 gm	☐ Apply a thin layer to affected area(s) once a day (Quantity: 1 tube)	

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	☐ (_____)	☐	_____
☐ Stelara	☐ (_____)	☐	_____
☐ 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:

PASI Score:
BSA ____% _____ SALT Score: ____

Date of Diagnosis: ____/____/_____

Allergies:

☐ L20.9 Atopic Dermatitis
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ L63.9 Alopecia areata, unspecified
☐ L80 Vitiligo
☐ Other: _____

Active TB 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

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.