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®** | ☐ 30 mg Starter Pack | ☐ Take as directed per package instructions (Quantity: 55) | |
| | ☐ 30 mg Tablet | ☐ Take 30 mg PO twice daily (Quantity: 60) | |
| **Rhapsido®** | 25 mg Tablet | ☐ Take 25 mg PO twice daily with or without food (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) | |

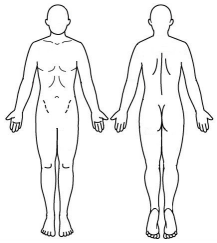
## MEDICAL INFORMATION

*****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)
☐ L50.8 Other Urticaria
☐ 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

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