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

Hidradenitis Suppurativa 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
Bimzelx®	☐ Pre-filled Syringe ☐ Autoinjector	☐ **INITIAL:** Inject 320 mg SQ on week 0, 2, 4, 6, 8, 10, 12, 14, and 16 (Quantity: 9) ☐ **MAINTENANCE:** Inject 320 mg SQ every 4 weeks (Quantity: 1)	
Cosentyx®	☐ Sensoready® Pen ☐ UnoReady® Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: QS 5 doses) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days) ☐ **MAINTENANCE:** Inject 300 mg SQ every 2 weeks (Quantity: QS 28 days) ***Intended for patients who did not adequately respond to Q4W dosing***	
Humira® ***Citrate Free***	☐ 80 mg Pen ☐ 40 mg Pre-filled Syringe ☐ 40 mg Pen	☐ **INITIAL:** Inject 160 mg (2 pens) SQ on day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 80 mg on day 15, then 40 mg SQ every week starting on day 29 (Quantity: 4) ***WEIGHT REQUIRED*** _____ ***Intended for weight ≥ 60 kg/132 lbs***	
	☐ 80 mg Pen	☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week starting on day 15 (Quantity: 2)	
	☐ 40 mg Pen ☐ 40 mg Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg (2 pens/syringes) SQ on day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ***Intended for patients 12 years of age and older weight 30 kg/66 lbs to <60 kg/132 lbs***	

MEDICAL INFORMATION

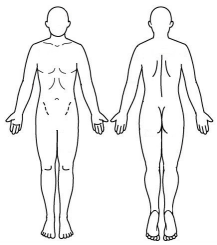
PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not tolerated:	Contraindication
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ L73.2 Hidradenitis suppurativa ☐ Other: _____

Allergies:

Date of Diagnosis: ____/____/_____



Affected Areas

☐ Groin ☐ Armpits ☐ Buttocks ☐ Breasts
☐ Other: _____

HIDRAscore: _____ HASI-R Score: _____

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

Additional Clinical Information:

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

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.