 <p>SENDERRA Specialty Pharmacy 3712 E. Plano Parkway, Ste. 200 Plano, TX 75074 <i>This prescription form is to be sent & received via fax</i></p>	Hidradenitis Suppurativa Enrollment Form	Prescriber:	NPI:
	Physician Offices Call: 855-460-7928	Supervising Physician:	NPI:
	Fax: 888-777-5645	Address:	Tax ID:
		Phone:	Fax:
		Contact:	

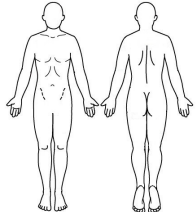
PATIENT INFORMATION			
Name:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: ____/____/____	SS#: ____-____-____
Street:	City:	State: _____	ZIP: _____
Phone:	Alt. Phone:	<input type="checkbox"/> 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
Bimzelx® <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Autoinjector	<input type="checkbox"/> INITIAL: Inject 320 mg SQ on week 0, 2, 4, 6, 8, 10, 12, 14, and 16 (Quantity: 9) <input type="checkbox"/> MAINTENANCE: Inject 320 mg SQ every 4 weeks (Quantity: 1)	
Cosentyx® <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> UnoReady® Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: QS 5 doses) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 2 weeks (Quantity: QS 28 days) <small>***Intended for patients who did not adequately respond to Q4W dosing***</small>	
Cosentyx® <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> Pre-filled Syringe	PEDIATRICS: ***WEIGHT REQUIRED*** <input type="checkbox"/> INITIAL: Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) <small>***Intended for weight ≥ 30 kg/66 lbs to <90 kg/198 lbs***</small> <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1)	
Cosentyx® <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> UnoReady® Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: QS 5 doses) <small>***Intended for weight ≥ 90 kg/198 lbs***</small> <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days)	
Humira® Citrate Free <input type="checkbox"/> 80 mg Pen <input type="checkbox"/> 40 mg Pre-filled Syringe <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 80 mg Pen	<input type="checkbox"/> INITIAL: Inject 160 mg (2 pens) SQ on day 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 80 mg on day 15, then 40 mg SQ every week starting on day 29 (Quantity: 4) <small>***WEIGHT REQUIRED***</small> <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every other week starting on day 15 (Quantity: 2) <small>***Intended for weight ≥ 60 kg/132 lbs***</small>	
<input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 80 mg (2 pens/syringes) SQ on day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <small>***Intended for patients 12 years of age and older weight 30 kg/66 lbs to <60 kg/132 lbs***</small> <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (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	 <p>Affected Areas</p> <input type="checkbox"/> Groin <input type="checkbox"/> Armpits <input type="checkbox"/> Buttocks <input type="checkbox"/> Breasts <input type="checkbox"/> Other: _____ HIDRAscore: _____ HASI-R Score: _____
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> L73.2 Hidradenitis suppurativa <input type="checkbox"/> Other: _____				
Allergies:				
Date of Diagnosis: ____/____/____				
Active TB is 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:

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

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