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

Pediatric Atopic Dermatitis Enrollment Form I-Z

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
Nemluvio®	☐ 30 mg Pen*	☐ **INITIAL:** Inject 60 mg (two 30 mg injections) SQ at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 30 mg SQ every 4 weeks (Quantity: 1) ☐ **MAINTENANCE:** Inject 30 mg SQ every 8 weeks (Quantity: 1) ***Intended for patients who achieve clear/almost clear skin after 16 weeks of treatment***	
Opzelura®	1.5 % Cream 60 gm*	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Rinvoq®	☐ 15 mg Tablet*	***WEIGHT REQUIRED*** _____ ☐ Take 15 mg PO once daily (Quantity: 30) ***Intended for patients age 12 years and older weighing ≥ 40 kg/88 lbs***	
	☐ 30 mg Tablet*	☐ Take 30 mg PO once daily (Quantity: 30) ***Intended for patients age 12 years and older weighing ≥ 40 kg/88 lbs if adequate response was not achieved with 15 mg daily dose***	
Vtama®	1% Cream 60 gm*	☐ Apply a thin layer to affected area(s) once a day (Quantity: 1 tube)	

**Nemluvio/Opzelura/Rinvoq FDA approved for ages 12 and older* **Vtama FDA approved for ages 2 and older*

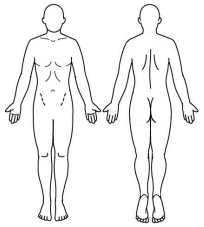
MEDICAL INFORMATION

*****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	☐ (_____)	☐	_____
☐ Cyclosporine	☐ (_____)	☐	_____
☐ Tacrolimus	☐ (_____)	☐	_____
☐ Elidel	☐ (_____)	☐	_____
☐ Protopic	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA /UVB	☐ (_____)	☐	_____

☐ Patient cannot afford ☐ Photosensitivity ☐ Risk of Skin Cancer ☐ Distance from Office



☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other:

Scoring tool used

☐ BSA ☐ EASI ☐ ISGA ☐ POEM
☐ SCORAD _____% or Score: _____

☐ L20.9 Atopic Dermatitis ☐ (**Mild to Moderate**) ☐ (**Moderate to Severe**)

☐ Other: _____ **Date of Diagnosis**: ____/____/_____

Allergies:

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