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 Dermatology Enrollment Form A-H**

**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 |
|---|---|---|---|---|
| **Cosentyx®** | ☐ 75 mg Pre-filled Syringe | ☐ **INITIAL:** Inject 75 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5)<br>☐ **MAINTENANCE:** Inject 75 mg SQ every 4 weeks (Quantity: 1) | ***WEIGHT REQUIRED*** _____<br>***Intended for weight < 50 kg/110 lbs*** | |
| | ☐ 150 mg Sensoready Pen<br>☐ 150 mg Pre-filled Syringe | ☐ **INITIAL:** Inject 150 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5)<br>☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) | ***Intended for weight ≥ 50 kg/110 lbs*** | |
| **Dupixent®** | ☐ Pen<br>☐ Pre-filled Syringe | ☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2) | ***WEIGHT REQUIRED*** _____<br>***Intended for weight ≥ 60 kg/132 lbs*** | |
| | | ☐ **INITIAL:** Inject 400 mg SQ (two 200 mg injections) at week 0 (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week starting at day 15 (Quantity: 2) | ***Intended for weight 30 kg/66 lbs to <60 kg/132lbs*** | |
| **Enbrel®** | ☐ SureClick® Pen<br>☐ Mini® with AutoTouch®<br>☐ Pre-filled Syringe<br>☐ 25 mg ☐ 50 mg<br>☐ 25 mg Vial | ☐ Inject ___ mg (0.8mg/kg x ___kg SQ every week) (Quantity: QS 1 month) | ***WEIGHT REQUIRED***<br>***Intended for weight < 63 kg/138 lbs*** | |
| | | ☐ Inject 50 mg SQ every week (Quantity: 4) | ***Intended for weight ≥ 63 kg/138 lbs*** | |
| **Humira®** ***Citrate Free*** | ☐ 80 mg Pen | ☐ **INITIAL:** Inject 160 mg (2 pens) SQ at day 1 (Quantity: 2) | ***WEIGHT REQUIRED***<br>***Intended for weight ≥ 60 kg/132 lbs*** | |
| | ☐ 40 mg Pen ☐ 40 mg Pre-filled Syringe | ☐ **MAINTENANCE:** Inject 80 mg (2 pens) SQ on day 15, then 40 mg once weekly starting at day 29 (Quantity: 4) | | |
| | ☐ 80 mg Pen | ☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week starting at day 29 (Quantity: 2) | | |
| | ☐ 40 mg Pen<br>☐ 40 mg Pre-filled Syringe | ☐ **INITIAL:** Inject 80 mg SQ (2 pens/syringes) at day 1, 40 mg at day 8, then 40 mg every **other** week (Quantity: 4)<br>☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) | ***Intended for weight 30 kg/66 lbs to <60 kg/132 lbs*** | |

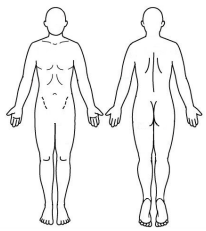
## MEDICAL INFORMATION

***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: |
|---|---|---|---|
| ☐ Methotrexate | ☐ (_____) | ☐ | _____ |
| ☐ 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:

BSA _____%

**Date of Diagnosis**: ____/____/_____ Allergies:_____

☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis) ☐ L50.8 Other Urticaria

☐ L73.2 Hidradenitis suppurativa ☐ Other: _____

Active TB ruled out: ☐Yes ☐No Date: __/__/____ Active Hep B ruled out: ☐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

## 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.