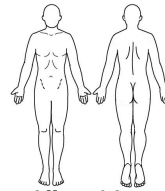
 <p>SENDERRA Specialty Pharmacy 3712 E. Plano Parkway, Ste. 200 Plano, TX 75074 <i>This prescription form is to be sent & received via fax</i></p>	Pediatric Dermatology Enrollment Form A-H	Prescriber: _____	NPI: _____
	Physician Offices Call: 855-460-7928	Supervising Physician: _____	NPI: _____
	Fax: 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	
Cosentyx® <input type="checkbox"/> 75 mg Pre-filled Syringe <input type="checkbox"/> 150 mg Sensoready Pen <input type="checkbox"/> 150 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 75 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) <input type="checkbox"/> MAINTENANCE: Inject 75 mg SQ every 4 weeks (Quantity: 1)	***WEIGHT REQUIRED*** _____ ***Intended for weight < 50 kg/110 lbs***	
	<input type="checkbox"/> INITIAL: Inject 150 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1)	***Intended for weight ≥ 50 kg/110 lbs***	
Dupixent® <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	PEDIATRIC PATIENTS 6 TO 17 YEARS OF AGE:		***WEIGHT REQUIRED*** _____
	<input type="checkbox"/> INITIAL: Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every other week starting at day 15 (Quantity: 2)	***Intended for weight ≥ 60 kg/132 lbs***	
	<input type="checkbox"/> INITIAL: Inject 400 mg SQ (two 200 mg injections) at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every other week starting at day 15 (Quantity: 2)	***Intended for weight 30 kg/66 lbs to <60 kg/132 lbs***	
	<input type="checkbox"/> INITIAL: Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks thereafter (Quantity: 1)	***Intended for weight 15 kg/33 lbs to <30 kg/66 lbs***	
	PEDIATRIC PATIENTS 2 TO 5 YEARS OF AGE:		
	<input type="checkbox"/> Inject 200 mg SQ every 4 weeks (Quantity: 1) <input type="checkbox"/> Inject 300 mg SQ every 4 weeks (Quantity: 1)	***Intended for weight 5 kg/11 lbs to <15 kg/33 lbs*** ***Intended for weight 15 kg/33 lbs to <30 kg/66 lbs***	
Enbrel® <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini® with AutoTouch® <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 25 mg Vial	<input type="checkbox"/> Inject ____ mg (0.8mg/kg x ____ kg SQ every week) (Quantity: QS 1 month)	***WEIGHT REQUIRED*** _____ ***Intended for weight < 63 kg/138 lbs***	
	<input type="checkbox"/> Inject 50 mg SQ every week (Quantity: 4)	***Intended for weight ≥ 63 kg/138 lbs***	
Humira® Citrate Free <input type="checkbox"/> 80 mg Pen <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Pre-filled Syringe <input type="checkbox"/> 80 mg Pen <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg (2 pens) SQ at day 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 80 mg (2 pens) SQ on day 15, then 40 mg once weekly starting at day 29 (Quantity: 4)	***WEIGHT REQUIRED*** _____ ***Intended for weight ≥ 60 kg/132 lbs***	
	<input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every other week starting at day 29 (Quantity: 2)		
	<input type="checkbox"/> INITIAL: Inject 80 mg SQ (2 pens/syringes) at day 1, 40 mg at day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> 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: <input type="checkbox"/> Methotrexate <input type="checkbox"/> Stelara <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> _____	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Contraindication: _____ _____ _____ _____
PHOTOTHERAPY <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/> _____ <input type="checkbox"/> Risk of Skin Cancer	Contraindication: <input type="checkbox"/> Distance from Office
Date of Diagnosis: ____/____/____		Allergies: _____	
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> L73.2 Hidradenitis suppurativa		<input type="checkbox"/> L50.8 Other Urticaria <input type="checkbox"/> Other: _____	
Active TB ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____		Active Hep B ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____	
Additional Clinical Information: _____			



Affected Areas

Face Feet Groin Hands
 Nails Scalp Other: _____

BSA _____%

American Academy of Dermatology Consensus Statement on Psoriasis Therapies	
<input type="checkbox"/> Psoriasis is covering greater than 10% of body surface area <input type="checkbox"/> Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships	<input type="checkbox"/> Psoriasis is on palms, soles, head and neck, or genitalia <input type="checkbox"/> Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints

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	
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.	