



Pediatric Dermatology Enrollment Form A-H

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

3712 E. Plano Parkway, Ste. 200
Plano, TX 75074

This prescription form is to be sent & received via fax

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® <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"/> Sensoready® Pen <input type="checkbox"/> UnoReady® Pen <input type="checkbox"/> 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 patients with plaque psoriasis weight ≥ 50 kg/110 lbs and patients with hidradenitis suppurativa weight ≥ 30 kg/66 lbs to <90 kg/198 lbs*** <input type="checkbox"/> INITIAL: Inject 300 mg SQ at 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) ***Intended for patients with hidradenitis suppurativa weight ≥ 90 kg/198 lbs	
Dupixent® <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	PEDIATRIC PATIENTS 6 TO 17 YEARS OF AGE: <input type="checkbox"/> INITIAL: Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) ***WEIGHT REQUIRED*** _____ <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) ***Intended for weight 30 kg/66 lbs to <60 kg/132 lbs*** <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every other week starting at day 15 (Quantity: 2) <input type="checkbox"/> INITIAL: Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) ***Intended for weight 15 kg/33 lbs to <30 kg/66 lbs*** <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks thereafter (Quantity: 1) PEDIATRIC PATIENTS 2 TO 5 YEARS OF AGE: <input type="checkbox"/> Inject 200 mg SQ every 4 weeks (Quantity: 1) ***Intended for weight 5 kg/11 lbs to <15 kg/33 lbs*** <input type="checkbox"/> Inject 300 mg SQ every 4 weeks (Quantity: 1) ***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) ***WEIGHT REQUIRED*** _____ <input type="checkbox"/> MAINTENANCE: Inject 80 mg (2 pens) SQ on day 15, then 40 mg once weekly starting at day 29 (Quantity: 4) ***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) ***Intended for weight 30 kg/66 lbs to <60 kg/132 lbs*** <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: <input type="checkbox"/> Methotrexate <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> _____	Tried & Failed (Duration): <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____) <input type="checkbox"/> (____)	Not Tolerated: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Contraindication: _____ _____ _____	<p>Affected Areas</p> <input type="checkbox"/> Face <input type="checkbox"/> Feet <input type="checkbox"/> Groin <input type="checkbox"/> Hands <input type="checkbox"/> Nails <input type="checkbox"/> Scalp <input type="checkbox"/> Other: BSA _____%
PHOTOTHERAPY <input type="checkbox"/> UVA /UVB <input type="checkbox"/> Patient cannot afford	Tried & Failed (Duration): <input type="checkbox"/> (____)	Not Tolerated: <input type="checkbox"/>	Contraindication: <input type="checkbox"/> Distance from Office	

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.