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
E-O

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:**_____

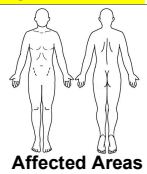
Drug		Directions & Quantity	Refills
Enbrel®	☐ SureClick® Pen ☐ Mini® with AutoTouch® ☐ Pre-filled Syringe ☐25 mg ☐50 mg ☐ 25 mg Vial	☐ Inject ___ mg (0.8mg/kg x ___kg SQ every week) (Quantity: QS 1 month) ***WEIGHT REQUIRED*** _____ ***Intended for weight < 63 kg/138 lbs***	
		☐ Inject 50 mg SQ every 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*** _____ ***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 ☐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) ***Intended for weight 30 kg/66 lbs to <60 kg/132 lbs***	
		☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
Icotyde™	200 mg Tablet	☐Take 200 mg PO once daily on an empty stomach with water upon waking & allow 30 minutes after taking before eating (Quantity: 30) ***WEIGHT REQUIRED*** _____ ***Intended for ages 12 and older weighing ≥ 40 kg/88 lbs***	
Opzelura®	1.5 % Cream 60 gm	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Otezla®	☐ 20 mg Starter Pack ☐ 30 mg Starter Pack	☐ **INITIAL:** Take as directed per package instructions (Quantity: 55) ***WEIGHT REQUIRED*** _____ ***20 mg starter pack intended for ages 6 and older weighing 20 kg/44 lbs to <50 kg/110 lbs***	
	XR Starter Pack	☐ **INITIAL:** Take as directed per package instructions (Quantity: 41) ***Intended for ages 6 and older weighing ≥ 50 kg/110 lbs***	
	20 mg Tablet	☐ **MAINTENANCE:** Take 20 mg PO twice daily (Quantity: 60) ***Intended for ages 6 and older weighing 20 kg/44 lbs to <50 kg/110 lbs***	
	30 mg Tablet	☐ **MAINTENANCE:** Take 30 mg PO twice daily (Quantity: 60) ***Intended for ages 6 and older weighing ≥ 50 kg/110 lbs***	
	XR 75 mg Tablet	☐ **MAINTENANCE:** Take 75 mg PO once daily (Quantity: 30) ***Intended for ages 6 and older weighing ≥ 50 kg/110 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:**
☐ Cosentyx	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
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:

☐L20.9 Atopic Dermatitis
☐L40. ____ _____
☐L80 Vitiligo
☐L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐L73.2 Hidradenitis suppurativa
☐ Other: _____

BSA _____% PASI Score: _____

Active TB ruled out: ☐Yes ☐No Date: ___/___/_____ Active Hep B ruled out: ☐Yes ☐No Date: ___/___/_____

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

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.