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 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:**_____

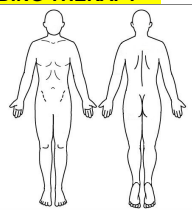
Drug		Directions & Quantity	Refills
Opzelura™	1.5 % Cream 60 gm	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Otezla®	☐ 20 mg Starter Pack ☐ 30 mg Starter Pack	☐ **INITIAL:** Take as directed per package instructions (Quantity: 55) ***WEIGHT REQUIRED*** _____ ***20 mg starter pack intended for ages 6 and older weighing 20 kg/44 lbs to <50 kg/110 lbs***	
	☐ 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***	
Stelara®	☐ 45 mg Vial	☐ **INITIAL:** Inject ___ mg (0.75 mg/kg x___kg) SQ at weeks 0 & 4 (Quantity: QS 2 doses) ☐ **MAINTENANCE:** Inject ___ mg (0.75 mg/kg x___kg) SQ every 12 weeks (Quantity: QS 1 dose) ***WEIGHT REQUIRED*** _____ ***Intended for weight < 60 kg/132 lbs***	
	☐ 45 mg Pre-filled Syringe	☐ **INITIAL:** Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 45 mg SQ every 12 weeks (Quantity: 1) ***Intended for weight 60 kg/132 lbs to 100 kg/220 lbs***	
	☐ 90 mg Pre-filled Syringe	☐ **INITIAL:** Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 90 mg SQ every 12 weeks (Quantity: 1) ***Intended for weight > 100 kg/220 lbs***	
Taltz®	☐ 80 mg Auto Injector ☐ 80 mg Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg (2 x 80 mg) SQ at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1) ***WEIGHT REQUIRED*** _____ ***Intended for weight > 50 kg/110 lbs***	
	☐ 80 mg Pre-filled Syringe ☐ 40 mg Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ at week 0 (Quantity: 1) ☐ **MAINTENANCE:** Inject 40 mg SQ every 4 weeks (thereafter) (Quantity: 1) ***Intended for weight 25 kg/55 lbs to 50 kg/110 lbs***	
	☐ 40 mg Pre-filled Syringe ☐ 20 mg Pre-filled Syringe	☐ **INITIAL:** Inject 40 mg SQ at week 0 (Quantity: 1) ☐ **MAINTENANCE:** Inject 20 mg SQ every 4 weeks (thereafter) (Quantity: 1) ***Intended for weight < 25 kg/55 lbs***	
Tremfya®	☐ 100 mg Pen ☐ 100 mg Pre-filled Syringe ☐ 100 mg One-Press Injector	☐ **INITIAL:** Inject 100 mg SQ at week 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 100 mg SQ every 8 weeks (Quantity: 1) ***WEIGHT REQUIRED*** _____ ***Intended for weight > 40 kg/88 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	☐ (_____)	☐	_____
☐ 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
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ L40. ____ _____
☐ L80 Vitiligo
☐ 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.