

 <h1 style="margin: 0;">SENDERRA</h1> <p style="font-size: small; margin: 0;">Specialty Pharmacy 3712 E. Plano Parkway, Ste. 200 Plano, TX 75074 <i>This prescription form is to be sent &amp; received via fax</i></p>	<b>Pediatric Psoriatic Arthritis Enrollment Form</b>  <b>Physician Offices Call:</b> <b>855-460-7928</b>  <b>Fax: 888-777-5645</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"><b>Prescriber:</b></td> <td><b>NPI:</b></td> </tr> <tr> <td colspan="2"><b>Supervising Physician:</b></td> <td><b>NPI:</b></td> </tr> <tr> <td colspan="2"><b>Address:</b></td> <td><b>Tax ID:</b></td> </tr> <tr> <td><b>Phone:</b></td> <td colspan="2"><b>Fax:</b></td> </tr> <tr> <td colspan="3"><b>Contact:</b></td> </tr> </table>	<b>Prescriber:</b>		<b>NPI:</b>	<b>Supervising Physician:</b>		<b>NPI:</b>	<b>Address:</b>		<b>Tax ID:</b>	<b>Phone:</b>	<b>Fax:</b>		<b>Contact:</b>		
	<b>Prescriber:</b>		<b>NPI:</b>														
	<b>Supervising Physician:</b>		<b>NPI:</b>														
	<b>Address:</b>		<b>Tax ID:</b>														
	<b>Phone:</b>	<b>Fax:</b>															
<b>Contact:</b>																	

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
<b>Cosentyx®</b>	<input type="checkbox"/> Pre-filled Syringe	<b>***WEIGHT REQUIRED***</b> <input type="checkbox"/> <b>INITIAL:</b> Inject 75 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) (≥ 15 kg/ 33 lbs to < 50 kg/ 110 lbs) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 75 mg SQ every 4 weeks (Quantity: 1)	
	<input type="checkbox"/> Sensoready® Pen	<input type="checkbox"/> <b>INITIAL:</b> Inject 150 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) (≥ 50 kg/ 110 lbs) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 150 mg SQ every 4 weeks (Quantity: 1)	
	<input type="checkbox"/> Pre-filled Syringe		
<b>Orencia®</b>	<input type="checkbox"/> Pre-filled Syringe	<b>***WEIGHT REQUIRED***</b> <input type="checkbox"/> Inject 50 mg SQ every week (Quantity: 4) (10 kg/ 22 lbs to < 25 kg/ 55 lbs) <input type="checkbox"/> Inject 87.5 mg SQ every week (Quantity: 4) (25 kg/ 55 lbs to < 50 kg/ 110 lbs) <input type="checkbox"/> Inject 125 mg SQ every week (Quantity: 4) (≥ 50 kg/ 110 lbs)	
	<input type="checkbox"/> ClickJect™		
<b>Rinvoq®</b>	15 mg Tablet	<b>***WEIGHT REQUIRED***</b> <input type="checkbox"/> Take 15 mg PO once daily (Quantity: 30) (≥ 30 kg/ 66 lbs)	
<b>Rinvoq® LQ</b>	1 mg/mL Solution	<b>***WEIGHT REQUIRED***</b> <input type="checkbox"/> Take 3 mg PO twice daily (Quantity: 1 bottle) (10 kg/ 22 lbs to < 20 kg/ 44 lbs) <input type="checkbox"/> Take 4 mg PO twice daily (Quantity: 1 bottle) (20 kg/ 44 lbs to < 30 kg/ 66 lbs) <input type="checkbox"/> Take 6 mg PO twice daily (Quantity: 2 bottles) (≥ 30 kg/ 66 lbs)	
<b>Stelara®</b>	<input type="checkbox"/> 45 mg Vial	<b>***WEIGHT REQUIRED***</b> <input type="checkbox"/> <b>INITIAL:</b> Inject ____ mg (0.75 mg/kg x ____ kg) SQ at weeks 0 & 4 (Quantity: QS 2 doses) (< 60 kg/ 132 lbs) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject ____ mg (0.75 mg/kg x ____ kg) SQ every 12 weeks (Quantity: QS 1 dose)	
	<input type="checkbox"/> 45 mg Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) (≥ 60 kg/ 132 lbs) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 45 mg SQ every 12 weeks (Quantity: 1)	
	<input type="checkbox"/> 90 mg Pre-filled Syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) (> 100 kg/ 220 lbs with co-existent moderate-to-severe plaque psoriasis) <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 90 mg SQ every 12 weeks (Quantity: 1)	

MEDICAL INFORMATION			
<b>***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY***</b>			
<b>PREVIOUS THERAPIES:</b> <input type="checkbox"/> Methotrexate <input type="checkbox"/> Naproxen <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>Tried &amp; Failed (Duration):</b> <input type="checkbox"/> (_____)	<b>Not Tolerated:</b> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>Contraindication:</b> _____ _____ _____ _____
<input type="checkbox"/> L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis)		<input type="checkbox"/> L40.54 Psoriatic juvenile arthropathy (JPsA)	
<input type="checkbox"/> Other: _____			
<b>Date of Diagnosis:</b> ____/____/____ <b>Allergies:</b> _____			
Active TB is ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____ Hep B ruled out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: ____/____/____			
<b>Additional Clinical Information:</b>			

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	
<b>To Prescriber:</b> 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.	
<b>Prescriber:</b> _____	<b>Date:</b> ____/____/____
CONFIDENTIALITY NOTICE	
<b>IMPORTANT:</b> 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.	