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 Psoriatic Arthritis Enrollment Form P-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
Rinvoq®	15 mg Tablet	***WEIGHT REQUIRED***_____ ☐ Take 15 mg PO once daily (Quantity: 30) **(≥ 30 kg/ 66 lbs)**	
Rinvoq® LQ	1 mg/mL Solution	***WEIGHT REQUIRED***_____ ☐ Take 3 mg PO twice daily (Quantity: 1 bottle) **(10 kg/ 22 lbs to < 20 kg/ 44 lbs)** ☐ Take 4 mg PO twice daily (Quantity: 1 bottle) **(20 kg/ 44 lbs to < 30 kg/ 66 lbs)** ☐ Take 6 mg PO twice daily (Quantity: 2 bottles) **(≥30 kg/ 66 lbs)**	
Skyrizi®	☐ 55 mg Pre-filled Syringe	☐ **INITIAL:** Inject 55 mg SQ at weeks 0 & 4 (Quantity: 1 plus 1 refill) ☐ **MAINTENANCE:** Inject 55 mg SQ every 12 weeks (Quantity: 1) ***WEIGHT REQUIRED***_____ ***Intended for weight < 40 kg/88 lbs***	
	☐ 150 mg Pen ☐ 150 mg Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ at weeks 0 & 4 (Quantity: 1 plus 1 refill) ☐ **MAINTENANCE:** Inject 150 mg SQ every 12 weeks (Quantity: 1) ***Intended for weight ≥ 40 kg/88 lbs***	
Stelara®	☐ 45 mg Vial	***WEIGHT REQUIRED***_____ ☐ **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) **(< 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) **(≥ 60 kg/ 132 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) **(> 100 kg/ 220 lbs with co-existent moderate-to-severe plaque psoriasis)**	
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***	
Xeljanz®	5 mg Tablet	☐ Take 5 mg PO twice daily (Quantity: 60)	
	1 mg/mL Solution	☐ Take 3.2 mg PO twice daily (Quantity: 240) **(10 kg/ 22 lbs to < 20 kg/ 44 lbs)** ☐ Take 4 mg PO twice daily (Quantity: 240) **(20 kg/ 44 lbs to < 40 kg/ 88 lbs)** ☐ Take 5 mg PO twice daily (Quantity: 240) **(≥40 kg/ 88 lbs)** ***WEIGHT REQUIRED***_____	

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	☐ (_____)	☐	_____
☐ Naproxen	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis) ☐ L40.54 Psoriatic juvenile arthropathy (JPsA)

☐ Other: _____

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

Active TB is ruled out: ☐Yes ☐No Date: ____/____/____ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/____

Additional Clinical Information:

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.