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 A-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
Cosentyx®	☐ Pre-filled Syringe	***WEIGHT REQUIRED***_____ ☐ **INITIAL:** Inject 75 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 75 mg SQ every 4 weeks (Quantity: 1) **(≥ 15 kg/ 33 lbs to < 50 kg/ 110 lbs)**	
	☐ Sensoready® Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) **(≥ 50 kg/ 110 lbs)**	
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: ____ x 25 mg/0.5 mL) **(<63 kg/ 138 lbs)** ***WEIGHT REQUIRED*** _____ ☐ Inject 50mg SQ every week (Quantity: 4) **(≥63 kg/ 138 lbs)**	
Orencia®	☐ Pre-filled Syringe ☐ ClickJect™	***WEIGHT REQUIRED***_____ ☐Inject 50 mg SQ every week (Quantity: 4) **(10 kg/ 22 lbs to < 25 kg/ 55 lbs)** ☐Inject 87.5 mg SQ every week (Quantity: 4) **(25 kg/ 55 lbs to < 50 kg/ 110 lbs)** ☐Inject 125 mg SQ every week (Quantity: 4) **(≥ 50 kg/ 110 lbs)**	
Otezla®	☐ 30 mg Starter Pack ☐ 20 mg Starter Pack	***WEIGHT REQUIRED***_____ ☐Take as directed per package instructions (Quantity: 55)	
	☐ XR Starter Pack	☐Take as directed per package instructions (Quantity: 41)	
	☐ 30 mg Tablet ☐ 20 mg Tablet	☐Take 30 mg PO twice daily (Quantity: 60) **(≥ 50 kg/ 110 lbs)** ☐Take 20 mg PO twice daily (Quantity: 60) **(20 kg/ 44 lbs to <50kg/110 lbs)**	
	☐ XR 75 mg Tablet	☐Take 75 mg PO once daily (Quantity: 30) **(≥ 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:
☐ 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.