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.

1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

Ancillary Immunology Enrollment Form

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.: ________

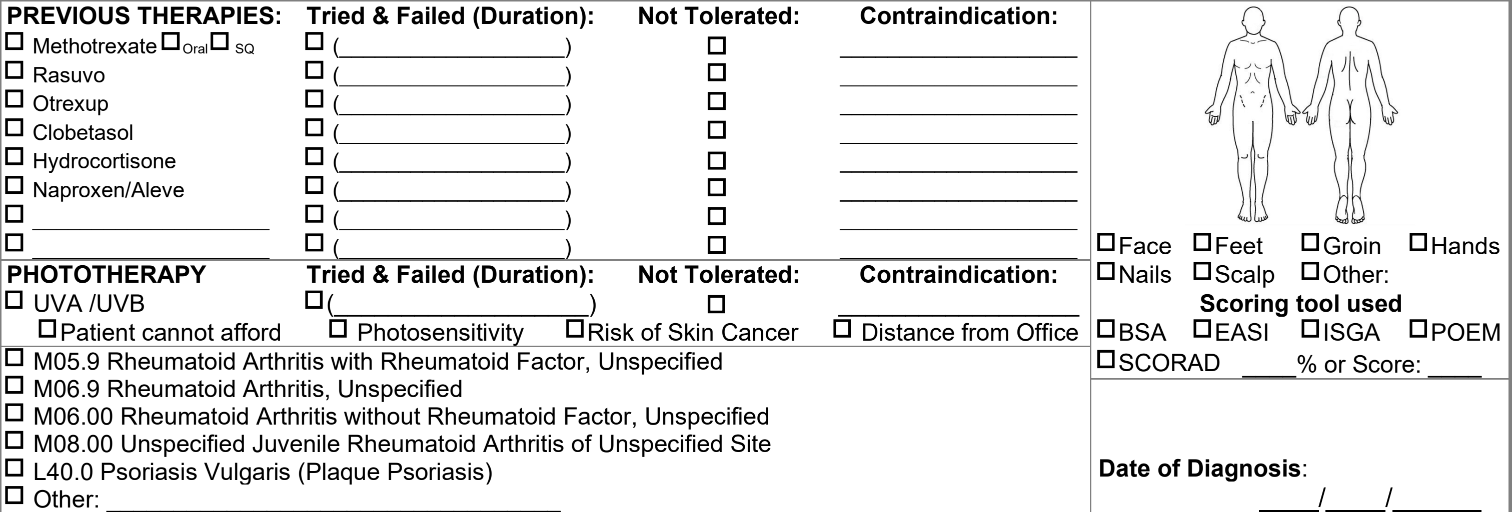
PRESCRIPTION

☐New ☐ Refill **Ship by: ____/____/_____** **SHIP TO: ☐ Patient's Home ☐ Doctor's Office ☐ Other: _______________**

Drug		Directions & Quantity				Refills
Methotrexate	☐ 2.5 mg tablet	☐ Take _____ tablet(s) PO every week (Quantity: 28-day supply)				
	☐ 25 mg/mL 2mL Inj Sol	☐ Inject _____ mL / _____mg SQ every 7 days the same day each week (Quantity: 28-day supply)				
Otrexup®	☐ 10 mg Auto Inj ☐ 12.5 mg Auto Inj	☐ 15 mg Auto Inj ☐ 17.5 mg Auto Inj	☐ 20 mg Auto Inj ☐ 22.5 mg Auto Inj	☐ 25 mg Auto Inj	Inject SQ every week (Quantity:4)	
Rasuvo®	☐ 7.5 mg Auto Inj ☐ 10 mg Auto Inj ☐ 12.5 mg Auto Inj	☐ 15 mg Auto Inj ☐ 17.5 mg Auto Inj ☐ 20 mg Auto Inj	☐22.5 mg Auto Inj ☐25 mg Auto Inj ☐27.5 mg Auto Inj	☐30 mg Auto Inj	Inject SQ every week (Quantity: 4)	
RediTrex®	☐ 7.5 mg PFS ☐10 mg PFS	☐12.5 mg PFS ☐15 mg PFS	☐17.5 mg PFS ☐20 mg PFS	☐22.5 mg PFS ☐ 25 mg PFS	Inject SQ every week (Quantity: 4)	

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 ☐Oral ☐ SQ	☐ (__________________)	☐	__________________
☐ Rasuvo	☐ (__________________)	☐	__________________
☐ Otrexup	☐ (__________________)	☐	__________________
☐ Clobetasol	☐ (__________________)	☐	__________________
☐ Hydrocortisone	☐ (__________________)	☐	__________________
☐ Naproxen/Aleve	☐ (__________________)	☐	__________________
☐ __________________	☐ (__________________)	☐	__________________
☐ __________________	☐ (__________________)	☐	__________________

PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA /UVB	☐(__________________)	☐	__________________

☐Patient cannot afford ☐ Photosensitivity ☐Risk of Skin Cancer ☐ Distance from Office

☐Face ☐Feet ☐Groin ☐Hands
☐Nails ☐Scalp ☐Other:

Scoring tool used

☐BSA ☐EASI ☐ISGA ☐POEM
☐SCORAD ____% or Score: ____

☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ Other: ____________________________________

Date of Diagnosis: ____/____/______

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

Allergies:____

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.