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

Atopic Dermatitis 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

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**
Adbry™	☐ 150 mg Pre-filled Syringe	☐ **INITIAL:** Inject 600 mg SQ on day 1 (Quantity: 4) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 4) ☐ **MAINTENANCE:** Inject 300 mg SQ **every 4 weeks** (Quantity: 2) *****Intended for patients who weigh below 100 kg who achieve clear/almost clear skin after 16 weeks of treatment*****	
Cibinqo™	☐ 100 mg Tablet ☐ 200 mg Tablet	☐ Take 100 mg PO once daily (Quantity: 30) ☐ Take 200 mg PO once daily (Quantity: 30) *****Intended for patients who have not achieved adequate response with 100 mg daily dose*****	
Dupixent®	☐ 300 mg Pre-filled Syringe ☐ 300 mg Pen	☐ **INITIAL:** Inject 600 mg SQ on day 1 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2)	
Eucrisa®	☐ 2% Ointment 60 gm ☐ 2% Ointment 100 gm	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Opzelura™	☐ 1.5 % Cream 60 gm	☐ Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Rinvoq®	☐ 15 mg Tablet ☐ 30 mg Tablet	☐ Take 15 mg PO once daily (Quantity: 30) *****Intended for patients age 65 and older***** ☐ Take 30 mg PO once daily (Quantity: 30) *****Intended for patients under age 65 who have not achieved adequate response with 15 mg daily dose*****	

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	☐ (________________)	☐	________________
☐ Cyclosporine	☐ (________________)	☐	________________
☐ Tacrolimus	☐ (________________)	☐	________________
☐ Elidel	☐ (________________)	☐	________________
☐ Protopic	☐ (________________)	☐	________________
☐ ________________	☐ (________________)	☐	________________
☐ ________________	☐ (________________)	☐	________________

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:

Scoring tool used

☐ BSA ☐ EASI ☐ ISGA ☐ POEM
☐ SCORAD ________% or Score: __________

☐ L20.9 Atopic Dermatitis (Moderate to Severe) ☐ 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

<u>**To Prescriber:**</u> 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.