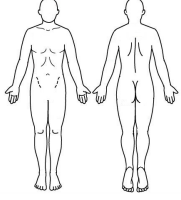
 <p>SENDERRA Specialty Pharmacy 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent & received via fax</i></p>	Dermatology Injectable Enrollment Form A-H	Prescriber:	NPI:	
	Physician Offices Call: 855-460-7928	Supervising Physician:	NPI:	
	Fax: 888-777-5645	Address:	Tax ID:	
		Phone:	Fax:	
		Contact:		

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	
Cimzia® <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> Inject 400 mg SQ every other week (Quantity: 4)		
Cosentyx® <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1) <input type="checkbox"/> INITIAL: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 10) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: 2)		
Enbrel® <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini® with AutoTouch® <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) <input type="checkbox"/> MAINTENANCE: Inject 50 mg SQ weekly (Quantity: 4)		
Humira® Citrate Free <input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 80 mg SQ on day 1, 40 mg on day 8, then 40 mg every other week (Quantity: QS 28 days) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every other week (Quantity: 2)		
<input type="checkbox"/> HS Starter Kit <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SQ on day 1, then 80 mg SQ on day 15 (Quantity: QS 28 days) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every other week starting on day 29 (Quantity: 2) *PEN ONLY* <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every week starting on day 29 (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:	
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	 <p>Affected Areas</p> <input type="checkbox"/> Face <input type="checkbox"/> Feet <input type="checkbox"/> Groin <input type="checkbox"/> Hands <input type="checkbox"/> Nails <input type="checkbox"/> Scalp <input type="checkbox"/> Other: _____ % Allergies: _____
<input type="checkbox"/> Soriatane	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Clobetasol	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Stelara	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/>	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:	
<input type="checkbox"/> UVA /UVB	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Patient cannot afford	<input type="checkbox"/> Photosensitivity	<input type="checkbox"/> Risk of Skin Cancer	<input type="checkbox"/> Distance from Office	
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis)		<input type="checkbox"/> L73.2 Hidradenitis suppurativa		
<input type="checkbox"/> Other:				Date of Diagnosis: _____ / _____ / _____
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: _____ / _____ / _____	
Additional Clinical Information:				

American Academy of Dermatology Consensus Statement on Psoriasis Therapies		
<input type="checkbox"/> Psoriasis is covering greater than 10% of body surface area	<input type="checkbox"/> Psoriasis is on palms, soles, head and neck, or genitalia	<input type="checkbox"/> Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
<input type="checkbox"/> Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships		
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		
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.		