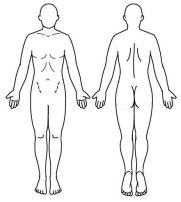
 <p>SENDERRA Specialty Pharmacy 1301 E. Arapaho Rd., Ste. 101 Richardson, TX 75081 <i>This prescription form is to be sent & received via fax</i></p>	Dermatology Injectable Enrollment Form I - Z	Prescriber:	NPI:
	Physician Offices Call: 855-460-7928	Supervising Physician:	NPI:
	Fax: 888-777-5645	Address:	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	
Ilumya®	<input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 100 mg SQ at weeks 0 & 4 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 12 weeks (Quantity: 1)		
Siliq®	<input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 210 mg SQ at weeks 0 & 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)		
Skyrizi®	<input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 150 mg SQ at weeks 0 & 4 (Quantity: 1 plus 1 refill) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 12 weeks (Quantity: 1)		
Stelara®	<input type="checkbox"/> 45 mg Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) ***WEIGHT REQUIRED*** _____ <input type="checkbox"/> MAINTENANCE: Inject 45 mg SQ every 12 weeks (Quantity: 1) ***Intended for weight ≤ 100 kg/220 lbs***		
	<input type="checkbox"/> 90 mg Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) ***Intended for weight > 100 kg/220 lbs*** <input type="checkbox"/> MAINTENANCE: Inject 90 mg SQ every 12 weeks (Quantity: 1)		
Taltz®	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> STARTING: Inject 160 mg (2 x 80 mg) SQ at week 0, then begin first induction dose 80 mg (1 x 80 mg) 2 weeks later (week 2) (Quantity: 3) <input type="checkbox"/> INDUCTION: Inject 80 mg SQ every 2 weeks (weeks 4-10) (Quantity: 2 plus 1 refill) <input type="checkbox"/> FINAL INDUCTION: Inject 80 mg SQ (week 12) (Quantity: 1) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1)		
Tremfya®	<input type="checkbox"/> One-Press Injector <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 100 mg SQ at week 0 & 4 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 8 weeks (Quantity: 1)		

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: _____ BSA % PASI Score: _____
<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"/>	_____	Date of Diagnosis: / /
<input type="checkbox"/> Patient cannot afford	<input type="checkbox"/> Photosensitivity	<input type="checkbox"/> Risk of Skin Cancer	<input type="checkbox"/> Distance from Office	Allergies:
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis)	<input type="checkbox"/> Other: _____			
Active TB 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

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.