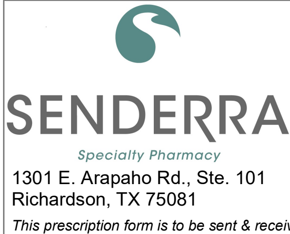

1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081

This prescription form is to be sent & received via fax

Juvenile Idiopathic Arthritis (JIA) Enrollment Form A-H

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
Actemra®	☐ Vial	**INTRAVENOUS (IV):** ☐ **PJIA –** Infuse 10 mg/kg every 4 weeks via IV **(< 30 kg)** ☐ **PJIA –** Infuse 8 mg/kg every 4 weeks via IV **(≥ 30 kg)** ☐ **SJIA –** Infuse 12 mg/kg every 2 weeks via IV **(< 30 kg)** ☐ **SJIA –** Infuse 8 mg/kg every 2 weeks via IV **(≥ 30 kg)** *****WEIGHT REQUIRED***** _______		
	☐ Pre-filled Syringe ☐ ACTPen®	**SUBCUTANEOUS (SQ):** ☐ **PJIA –** Inject 162 mg SQ once every 3 weeks **(< 30 kg)**	1	
		☐ **PJIA –** Inject 162 mg SQ once every 2 weeks **(≥ 30 kg)** *****WEIGHT REQUIRED*****	2	
		☐ **SJIA –** Inject 162 mg SQ once every 2 weeks **(< 30 kg)** _______	2	
		☐ **SJIA –** Inject 162 mg SQ once weekly **(≥ 30 kg)**	4	
Cosentyx®	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 75 mg SQ at week 0, 1, 2, 3, and 4 (**≥ 15 kg to < 50 kg**) *****WEIGHT REQUIRED*****	5	
		☐ **MAINTENANCE:** Inject 75 mg SQ every 4 weeks	1	
	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ at week 0, 1, 2, 3, and 4 (**≥ 50 kg**) _______	5	
		☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks	1	
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) (**≤63 kg)** *****WEIGHT REQUIRED***** _______	_____ x 25 mg/0.5 mL	
		☐ Inject 50 mg SQ every week **(>63 kg)**	4	
Humira® *Citrate Free*	☐ Pre-filled Syringe ☐ Pen	☐ Inject 10 mg SQ every **other** week (**10 kg to <15 kg)** ☐ Inject 20 mg SQ every **other** week (**15 kg to <30 kg)** ☐ Inject 40 mg SQ every **other** week (**≥ 30 kg)** *****WEIGHT REQUIRED***** _______		

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	☐(__________________)	☐	______________________________
☐ Enbrel	☐(__________________)	☐	______________________________
☐ Humira	☐(__________________)	☐	______________________________
☐ ________________	☐(__________________)	☐	______________________________

Date of Diagnosis: ____/____/_______ Allergies:_______________________________

☐ M08.00 Unspecified juvenile idiopathic arthritis of unspecified site

☐ M08.09 Unspecified juvenile rheumatoid arthritis, multiple sites (pcJIA)

☐ M08.80 Other juvenile arthritis, unspecified site (Enthesitis-related arthritis)

☐ L40.54 Psoriatic juvenile arthropthy (JPsA)

☐ Other: ____

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

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