



**Pediatric Dermatology  
Enrollment Form  
I-Z**

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
<b>Opzelura™</b> 1.5 % Cream 60 gm	<input type="checkbox"/> Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
<b>Stelara®</b>	<input type="checkbox"/> 45 mg Vial <input type="checkbox"/> INITIAL: Inject ____ mg (0.75 mg/kg x ____kg) SQ at weeks 0 & 4 (Quantity: QS 2 doses) <input type="checkbox"/> MAINTENANCE: Inject ____ mg (0.75 mg/kg x ____kg) SQ every 12 weeks (Quantity: QS 1 dose)	***WEIGHT REQUIRED*** _____ ***Intended for weight < 60 kg/132 lbs***
	<input type="checkbox"/> 45 mg Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 45 mg SQ every 12 weeks (Quantity: 1)	***Intended for weight 60 kg/132 lbs to 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) <input type="checkbox"/> MAINTENANCE: Inject 90 mg SQ every 12 weeks (Quantity: 1)	***Intended for weight > 100 kg/220 lbs***
<b>Taltz®</b>	<input type="checkbox"/> 80 mg Auto Injector <input type="checkbox"/> 80 mg Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 160 mg (2 x 80 mg) SQ at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1)	***WEIGHT REQUIRED*** _____ ***Intended for weight > 50 kg/110 lbs***
	<input type="checkbox"/> 80 mg Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 80 mg SQ at week 0 (Quantity: 1) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ every 4 weeks (thereafter) (Quantity: 1)	***Intended for weight 25 kg/55 lbs to 50 kg/110 lbs***
	<input type="checkbox"/> 80 mg Pre-filled Syringe <input type="checkbox"/> INITIAL: Inject 40 mg SQ at week 0 (Quantity: 1) <input type="checkbox"/> MAINTENANCE: Inject 20 mg SQ every 4 weeks (thereafter) (Quantity: 1)	***Intended for weight < 25 kg/55 lbs***

**MEDICAL INFORMATION**

\*\*\*PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY\*\*\*

<b>PREVIOUS THERAPIES:</b>	<b>Tried &amp; Failed (Duration):</b>	<b>Not Tolerated:</b>	<b>Contraindication:</b>	<p><b>Affected Areas</b></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: _____
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Cosentyx	<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"/>	_____	
<b>PHOTOTHERAPY</b>	<b>Tried &amp; Failed (Duration):</b>	<b>Not Tolerated:</b>	<b>Contraindication:</b>	
<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"/> L40. _____		
<input type="checkbox"/> Other: _____		<input type="checkbox"/> L80 Vitiligo		
Active TB ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: ____/____/____		Active Hep B ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: ____/____/____		BSA _____%    PASI Score: _____
Allergies: _____		Date of Diagnosis: ____/____/____		

**Additional Clinical Information:**

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**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**

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