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.

SENDERRA
Specialty Pharmacy

1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent & received via fax

Psoriatic Arthritis 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 patient received a loading dose/starter kit? ☐ **Yes Start Date:** ____/____/____ ☐ **No** | **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug		Directions & Quantity	Refills
Orencia®	☐ 250 mg Vials ☐ Pre-filled Syringe ☐ ClickJect ™	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV at week 0, 2, and 4 (Quantity: QS 3 doses) ☐ **MAINTENANCE:** Infuse _____ mg via IV every 4 weeks (Quantity: QS 1 dose) **SUBCUTANEOUS (SQ):** ☐ Inject 125mg SQ once weekly (Quantity: 4)	
Otezla®	☐ 28 Day Starter Pack	☐ Take as directed per package instructions (Quantity: 55)	
	☐ 30 mg Tablets	☐ Take 30 mg PO twice daily (Quantity: 60)	
Rinvoq®	15 mg Tablets	☐ Take 15 mg PO once daily (Quantity: 30)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month (Quantity: 1)	
Skyrizi®	☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ at weeks 0 & 4 (Quantity: 1 plus 1 refill) ☐ **MAINTENANCE:** Inject 150 mg SQ every 12 weeks (Quantity: 1)	
Stelara®	☐ Pre-filled Syringe **Weight Required: _____**	☐ **INITIAL:** Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 45 mg SQ every 12 weeks (Quantity: 1) ☐ **INITIAL:** Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 90 mg SQ every 12 weeks (Quantity: 1) *****WEIGHT BASED GUIDELINES***** **Less than or equal to 100 kg (220 lbs): 45 mg** **Greater than 100 kg (220 lbs): 90 mg**	
Taltz®	☐ Auto Injector ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg (2 x 80 mg) SQ at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1) ☐ **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) ☐ **INDUCTION:** Inject 80 mg SQ every 2 weeks (weeks 4-10) (Quantity: 2 plus 1 refill) ☐ **FINAL INDUCTION:** Inject 80 mg SQ (week 12) (Quantity: 1) ☐ **MAINTENANCE:** Inject 80 mg SQ every 4 weeks (thereafter) (Quantity: 1)	
Tremfya®	☐ One-Press Injector ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 100 mg SQ at week 0 & 4 (Quantity: 2) ☐ **MAINTENANCE:** Inject 100 mg SQ every 8 weeks (Quantity: 1)	
Xeljanz®	5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)	

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	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Naproxen / Aleve	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis) ☐ L40.52 Psoriatic Arthritis Mutilans
☐ L40.59 Other Psoriatic Arthropathy ☐ 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

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.