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
3712 E. Plano Parkway, Ste. 200
Plano, TX 75074
This prescription form is to be sent & received via fax

Psoriatic Arthritis 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

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
Bimzelx®	☐Pre-filled Syringe ☐ Autoinjector	☐ **INITIAL:** Inject 320 mg SQ at week 0, 4, 8, 12, and 16 (Quantity: 5) ☐ **MAINTENANCE:** Inject 320 mg SQ every 8 weeks (Quantity: 1) ☐ **MAINTENANCE:** Inject 320 mg SQ every 4 weeks (Quantity: 1) ***Intended for patients ≥ 120 kg (264 lbs)*** *****Intended for patients with coexistent moderate-to-severe plaque psoriasis***** ☐ Inject 160 mg SQ every 4 weeks (Quantity: 1)	
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Cosentyx®	☐ Sensoready® Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1)	
	☐ Sensoready® Pen ☐ UnoReady® Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 300 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: QS 5 doses) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days)	
Enbrel®	☐ SureClick® Pen ☐ Mini® with AutoTouch® ☐ Pre-filled Syringe	☐ Inject 50 mg SQ every week (Quantity: 4)	
Humira® ***Citrate Free***	☐ Pen ☐ Pre-filled Syringe	☐Inject 40 mg SQ every **other** week (Quantity: 2)	

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	☐ (_____)	☐	_____
☐ Plaquenil	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ 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.