



Psoriatic Arthritis Enrollment Form I - Z

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

3712 E. Plano Parkway, Ste. 200
Plano, TX 75074

This prescription form is to be sent & received via fax

Prescriber:		NPI:
Supervising Physician:		NPI:
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 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®	<input type="checkbox"/> 250 mg Vial	INTRAVENOUS (IV): <input type="checkbox"/> INITIAL: Infuse _____ mg via IV at week 0, 2, and 4 (Quantity: QS 3 doses) <input type="checkbox"/> MAINTENANCE: Infuse _____ mg via IV every 4 weeks (Quantity: QS 1 dose) SUBCUTANEOUS (SQ): <input type="checkbox"/> Inject 125mg SQ once weekly (Quantity: 4)	
	<input type="checkbox"/> Pre-filled Syringe		
Otezla®	<input type="checkbox"/> ClickJect™		
	<input type="checkbox"/> 30 mg Starter Pack	<input type="checkbox"/> Take as directed per package instructions (Quantity: 55)	
	<input type="checkbox"/> XR Starter Pack	<input type="checkbox"/> Take as directed per package instructions (Quantity: 41)	
	<input type="checkbox"/> 30 mg Tablet	<input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 60)	
Rinvoq®	<input type="checkbox"/> XR 75mg Tablet	<input type="checkbox"/> Take 75 mg PO once daily (Quantity: 30)	
	<input type="checkbox"/> 15 mg Tablet	<input type="checkbox"/> Take 15 mg PO once daily (Quantity: 30)	
Simponi®	<input type="checkbox"/> SmartJect® (Pen)	<input type="checkbox"/> Inject 50 mg SQ once a month (Quantity: 1)	
	<input type="checkbox"/> Pre-filled Syringe		
Skyrizi®	<input type="checkbox"/> Pen	<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)	
	<input type="checkbox"/> Pre-filled Syringe		
Sotyktu™	<input type="checkbox"/> 6 mg Tablet	<input type="checkbox"/> Take 6 mg PO once daily with or without food (Quantity: 30)	
Stelara®	<input type="checkbox"/> 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) <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)	***WEIGHT BASED GUIDELINES*** Less than or equal to 100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90 mg
	Weight Required: _____		
Taltz®	<input type="checkbox"/> Auto Injector	<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) <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)	
	<input type="checkbox"/> Pre-filled Syringe		
Tremfya®	<input type="checkbox"/> Pen	<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)	
	<input type="checkbox"/> One-Press Injector		
	<input type="checkbox"/> Pre-filled Syringe		
Xeljanz®	<input type="checkbox"/> 5 mg Tablet	<input type="checkbox"/> Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	<input type="checkbox"/> 11 mg Tablet	<input type="checkbox"/> 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:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Naproxen / Aleve	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> L40.50 Arthropathic Psoriasis, Unspecified (Psoriatic Arthritis) <input type="checkbox"/> L40.59 Other Psoriatic Arthropathy		<input type="checkbox"/> L40.52 Psoriatic Arthritis Mutilans <input type="checkbox"/> Other: _____	
Date of Diagnosis: / /		Allergies:	
Active TB is 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:			

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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