



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

This prescription form is to be sent & received via fax

Adalimumab Biosimilar
Abrilada
Amjevita
Cyltezo
Enrollment Form

Physician Offices Call:
855-460-7928

Fax: 888-777-5645

Prescriber:

Supervising Physician:

Address:

Phone: **Fax:**

Contact:

NPI:

NPI:

Tax ID:

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
Abrilada™ <div> <input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.8 mL Pre-filled Syringe <input type="checkbox"/> 20 mg/0.4 mL Pre-filled Syringe </div>	INITIAL/LOADING DOSES: ***WEIGHT REQUIRED*** <input type="checkbox"/> PSORIASIS/UEVITIS: Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> CROHN'S/UC/HS: Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** <input type="checkbox"/> PEDIATRIC CROHN'S: Inject 80 mg on SQ on day 1, 40 mg on day 15, then 20 mg every other week starting on day 29 (Quantity: QS) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** MAINTENANCE DOSES: <input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2) <input type="checkbox"/> Inject 40 mg SQ weekly (Quantity: 4) <input type="checkbox"/> Inject 80 mg SQ every other week (Quantity: 4) <input type="checkbox"/> Inject 20 mg SQ every other week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***	
Amjevita™ <div> <input type="checkbox"/> 80 mg/0.8 mL Sureclick® Autoinjector <input type="checkbox"/> 40 mg/0.8 mL Sureclick® Autoinjector <input type="checkbox"/> 40 mg/0.4 mL Sureclick® Autoinjector <input type="checkbox"/> Pre-filled Syringe <div> <input type="checkbox"/> 40 mg/0.8 mL <input type="checkbox"/> 40 mg/0.4 mL <input type="checkbox"/> 20 mg/0.4 mL <input type="checkbox"/> 20 mg/0.2 mL <input type="checkbox"/> 10mg/0.2 mL </div> </div>	INITIAL/LOADING DOSES: ***WEIGHT REQUIRED*** <input type="checkbox"/> PSORIASIS/UEVITIS: Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every other week (Quantity: QS 28 Days) <input type="checkbox"/> CROHN'S/UC/HS: Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: QS 28 Days) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** <input type="checkbox"/> PEDIATRIC CROHN'S: Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: QS 28 Days) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** MAINTENANCE DOSES: <input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2) <input type="checkbox"/> Inject 40 mg SQ weekly (Quantity: 4) <input type="checkbox"/> Inject 80 mg SQ every other week (Quantity: 4) <input type="checkbox"/> Inject 10 mg SQ every other week (Quantity: 2) ***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)*** <input type="checkbox"/> Inject 20 mg SQ every other week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***	
Cyltezo® <div> <input type="checkbox"/> Psoriasis/Uveitis Starter Package <input type="checkbox"/> Crohn's/UC/HS Starter Package <input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> Pre-filled Syringe <div> <input type="checkbox"/> 40 mg/0.8 mL <input type="checkbox"/> 40 mg/0.4 mL <input type="checkbox"/> 20 mg/0.4 mL <input type="checkbox"/> 10mg/0.2mL </div> </div>	INITIAL/LOADING DOSES: ***WEIGHT REQUIRED*** <input type="checkbox"/> PSORIASIS/UEVITIS: Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every other week (Quantity: 4) <input type="checkbox"/> CROHN'S/UC/HS: Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** <input type="checkbox"/> PEDIATRIC CROHN'S: Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: 3) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** MAINTENANCE DOSES: <input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2) <input type="checkbox"/> Inject 40 mg SQ weekly (Quantity: 4) <input type="checkbox"/> Inject 80 mg SQ every other week (Quantity: 4) <input type="checkbox"/> Inject 10 mg SQ every other week (Quantity: 2) ***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)*** <input type="checkbox"/> Inject 20 mg SQ every other week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***	

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

☐ H20.9 Iridocyclitis (Uveitis), unspecified
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ M06.9 Rheumatoid Arthritis, unspecified
☐ Other:

☐ K50.90 Crohn's disease unspecified, without complications
☐ L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
☐ M08.09 Unspecified juvenile RA, multiple sites (pcJIA)

☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ L73.2 Hidradenitis suppurativa
☐ M45.9 Ankylosing Spondylitis, unspecified

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.

Adalimumab Biosimilar-Abrilada/Amjevita/Cyltezo (Rev.12/04/2024)