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*

**Adalimumab Biosimilar**
**Hadlima**
**Hulio**
**Hyrimoz**
**Enrollment Form**

**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 |
|---|---|---|---|
| **Hadlima™** | ☐ 40 mg/0.8 mL PushTouch Autoinjector<br>☐ 40 mg/0.4 mL PushTouch Autoinjector<br>☐ 40 mg/0.8 mL Pre-filled Syringe<br>☐ 40 mg/0.4 mL Pre-filled Syringe | **INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** <br>☐ **PSORIASIS/UVEITIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4)<br>☐ **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)***<br>**MAINTENANCE DOSES:**<br>☐ Inject 40 mg SQ every **other** week (Quantity: 2)<br>☐ Inject 40 mg SQ weekly (Quantity: 4)<br>☐ Inject 80 mg SQ every **other** week (Quantity: 4) | |
| **Hulio®** | ☐ 40 mg/0.8 mL Pen<br>☐ Pre-filled Syringe<br>☐ 40 mg/0.8 mL<br>☐ 20 mg/0.4 mL | **INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** <br>☐ **PSORIASIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4)<br>☐ **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)***<br>☐ **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)***<br>**MAINTENANCE DOSES:**<br>☐ Inject 40 mg SQ every **other** week (Quantity: 2)<br>☐ Inject 40 mg SQ weekly (Quantity: 4)<br>☐ Inject 80 mg SQ every **other** week (Quantity: 4)<br>☐ 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)*** | |
| **Hyrimoz®** | ☐ Psoriasis Starter Package<br>☐ Crohn's/UC/HS Starter Package<br>☐ Pediatric Crohn's Starter Package<br>☐ 80 mg/0.8 mL Pre-Filled Syringe<br>☐ 80 mg/0.8 mL and 40 mg/0.4 mL Pre-Filled Syringe<br>☐ 40 mg/0.4 mL Sensoready® Pen<br>☐ 80 mg/0.8 mL Sensoready® Pen<br>☐ 40 mg/0.4 mL Pre-filled Syringe<br>☐ 20 mg/0.2 mL Pre-filled Syringe<br>☐ 10 mg/0.1 mL Pre-filled Syringe | **INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** <br>☐ **PSORIASIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: QS 28 days)<br>☐ **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 ≥ 40 kg (88 lbs)***<br>☐ **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)***<br>**MAINTENANCE DOSES:**<br>☐ Inject 40 mg SQ every **other** week (Quantity: 2)<br>☐ Inject 40 mg SQ weekly (Quantity: 4)<br>☐ Inject 80 mg SQ every **other** week (Quantity: QS 28 days)<br>☐ Inject 10 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)***<br>☐ 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
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
☐ L73.2 Hidradenitis suppurativa
☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, unspecified
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, multiple sites
☐ M06.9 Rheumatoid Arthritis, unspecified
☐ M08.09 Unspecified juvenile RA, multiple sites (pcJIA)
☐ M45.9 Ankylosing Spondylitis, unspecified
☐ 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

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