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

Ustekinumab Biosimilar 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
☐**Imuldosa®***** ☐**Otulfi®***** ☐**Pyzchiva®** ☐**Selarsdi™***** ☐**Steqeyma®***** ☐**Wezlana™** ☐**Yesintek™**	☐ 45 mg Pre-filled Syringe ☐ 90 mg Pre-filled Syringe ☐ 45 mg Vial ☐ 130 mg/26mL Vial	**ADULT INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____***	
		☐ **PSORIASIS/PSA:** Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) — ***Intended for psoriatic arthritis patients OR psoriasis patients ≤ 100 kg (220 lbs)***	
		☐ **PSORIASIS/PSA:** Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) — ***Intended for patients > 100 kg (220 lbs) with psoriasis OR psoriatic arthritis with co-existent moderate-to-severe plaque psoriasis ***	
		☐ **UC/CROHN'S:** A single intravenous infusion using weight-based dosing: Up to 55 kg=260 mg (2 vials), >55 kg to 85 kg=390 mg (3 vials), >85 kg=520 mg (4 vials)	
		PEDIATRIC INITIAL/LOADING DOSES:	
		☐ **PEDIATRIC PSORIASIS/PSA:** Inject ___ mg (0.75mg/kg x___kg) SQ at weeks 0 & 4 (Quantity: QS 2 doses) — ***Intended for patients < 60 kg (132 lbs)***	
		☐ **PEDIATRIC PSORIASIS/PSA:** Inject 45 mg SQ at weeks 0 & 4 (Quantity: 2) — ***Intended for patients 60 kg (132 lbs) to 100 kg (220 lbs)***	
		☐ **PEDIATRIC PSORIASIS:** Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) — ***Intended for patients > 100 kg (220 lbs)***	
		☐ **PEDIATRIC PSA:** Inject 90 mg SQ at weeks 0 & 4 (Quantity: 2) — ***Intended for patients > 100 kg (220 lbs) with co-existent moderate-to-severe plaque psoriasis***	
		ADULT MAINTENANCE DOSES: ***WEIGHT REQUIRED_____***	
		☐ **PSORIASIS/PSA:** Inject 45 mg SQ every 12 weeks (Quantity: 1) — ***Intended for psoriatic arthritis patients OR psoriasis patients ≤ 100 kg (220 lbs)***	
		☐ **PSORIASIS/PSA:** Inject 90 mg SQ every 12 weeks (Quantity: 1) — ***Intended for patients > 100 kg (220 lbs) with psoriasis OR psoriatic arthritis with co-existent moderate-to-severe plaque psoriasis ***	
		☐ **UC/CROHN'S:** Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (Quantity: 1 syringe)	
		PEDIATRIC MAINTENANCE DOSES:	
		☐ **PEDIATRIC PSORIASIS/PSA:** Inject ___ mg (0.75mg/kg x___kg) SQ every 12 weeks (Quantity: QS 1 dose) — ***Intended for patients < 60 kg (132 lbs)***	
		☐ **PEDIATRIC PSORIASIS/PSA:** Inject 45 mg SQ every 12 weeks (Quantity: 1) — ***Intended for patients 60 kg (132 lbs) to 100 kg (220 lbs)***	
		☐ **PEDIATRIC PSORIASIS:** Inject 90 mg SQ every 12 weeks (Quantity: 1) — ***Intended for patients > 100 kg (220 lbs)***	
		☐ **PEDIATRIC PSA:** Inject 90 mg SQ every 12 weeks (Quantity: 1) — ***Intended for patients > 100 kg (220 lbs) with co-existent moderate-to-severe plaque psoriasis***	

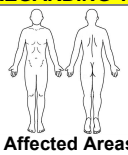
*****45 mg vial not available*

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	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
PHOTOTHERAPY	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ UVA /UVB	☐ (_____)	☐	_____

☐Patient cannot afford ☐Photosensitivity ☐Risk of Skin Cancer ☐Distance from Office



Affected Areas

☐ Face ☐ Feet ☐ Groin ☐ Hands
☐ Nails ☐ Scalp ☐ Other: _____
BSA ____% PASI Score ____

Allergies:

☐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)
☐ Other: _____

Date of Diagnosis: ____/____/_____

Active TB is ruled out: ☐Yes ☐No Date: ____/____/_____ Hep B ruled out/treated: ☐Yes ☐No Date: ____/____/_____

Additional Clinical Information:

INJECTION TRAINING

☐Patient has received 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.