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

Alopecia Areata 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**
Olumiant®	☐2 mg Tablet	☐ Take 2 mg PO once daily (Quantity: 30)	
	☐4 mg Tablet	☐ Take 4 mg PO once daily (Quantity: 30)	
Litfulo™	50 mg Capsule	☐ Take 50 mg PO once daily (Quantity: 28)	

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	☐ (_____)	☐	_____
☐ Prednisone	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

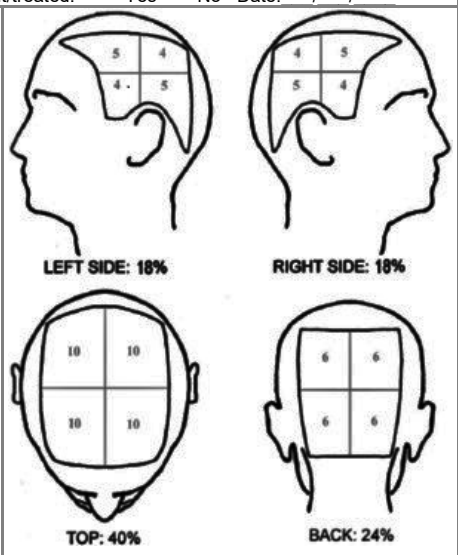
Allergies:

Date of Diagnosis: _____/_____/_____

☐ L63.9 Alopecia areata, unspecified ☐ Other: _____

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

Additional Clinical Information:



SALT Score: _____

Affected Areas:

☐ Scalp % of hair loss____

☐ Non-scalp (specify below)

☐ Face % of hair loss____

☐ Nails % affected ____

☐ Other: _____ % of hair loss____

AA Scale

☐ Mild AA (20% or less scalp hair loss)

☐ Moderate AA (21%-49% scalp hair loss)

☐ Severe AA (50%-100% scalp hair loss)

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.