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

This prescription form is to be sent & received via fax

Ancillary Immunology 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.: ________

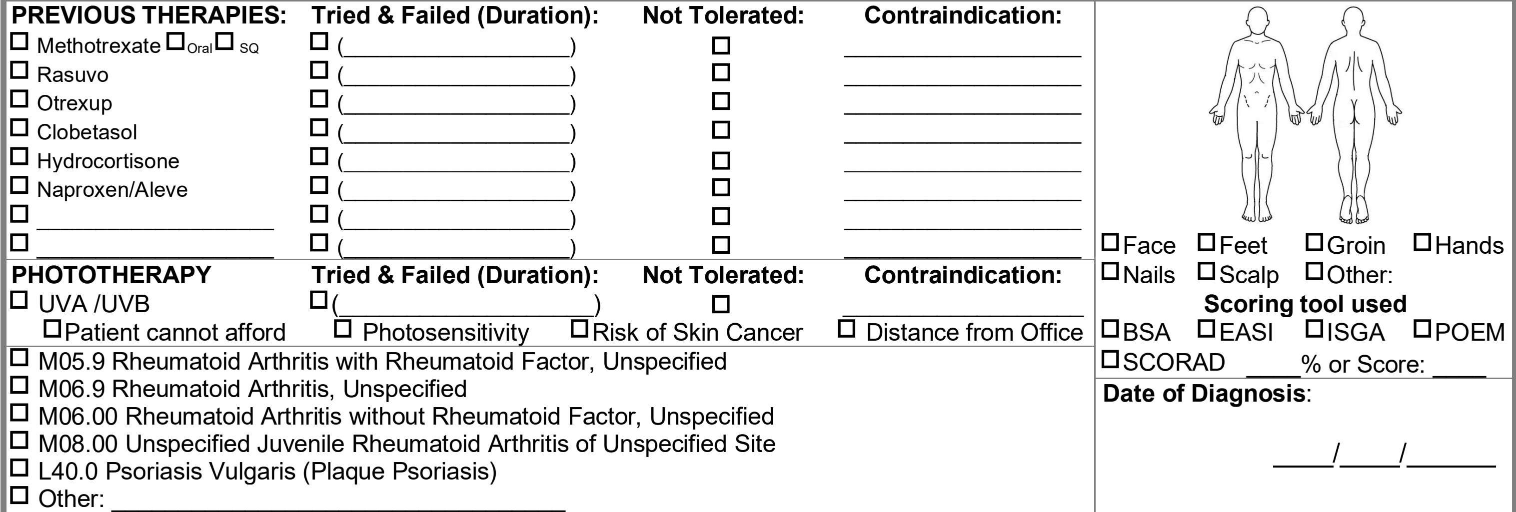
PRESCRIPTION

☐**New** ☐ **Refill** | **Ship by: ____/____/_____** | **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other: ________________**

Drug		**Directions & Quantity**				**Refills**
Methotrexate	☐ 2.5 mg tablet	☐ Take _____ tablet(s) PO every week (Quantity: 28-day supply)				
	☐ 25 mg/mL 2mL Inj Sol	☐ Inject _____ mL / _____mg SQ every 7 days the same day each week (Quantity: 28-day supply)				
Otrexup®	☐ 10 mg Auto Inj ☐ 12.5 mg Auto Inj	☐ 15 mg Auto Inj ☐ 17.5 mg Auto Inj	☐ 20 mg Auto Inj ☐ 22.5 mg Auto Inj	☐ 25 mg Auto Inj	Inject SQ every week (Quantity:4)	
Rasuvo®	☐ 7.5 mg Auto Inj ☐ 10 mg Auto Inj ☐ 12.5 mg Auto Inj	☐ 15 mg Auto Inj ☐ 17.5 mg Auto Inj ☐ 20 mg Auto Inj	☐22.5 mg Auto Inj ☐25 mg Auto Inj ☐27.5 mg Auto Inj	☐30 mg Auto Inj	Inject SQ every week (Quantity: 4)	
RediTrex®	☐ 7.5 mg PFS ☐ 10 mg PFS	☐ 12.5 mg PFS ☐ 15 mg PFS	☐ 17.5 mg PFS ☐ 20 mg PFS	☐ 22.5 mg PFS ☐ 25 mg PFS	Inject SQ every week (Quantity: 4)	

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 ☐Oral ☐ SQ	☐ (________________)	☐	________________
☐ Rasuvo	☐ (________________)	☐	________________
☐ Otrexup	☐ (________________)	☐	________________
☐ Clobetasol	☐ (________________)	☐	________________
☐ Hydrocortisone	☐ (________________)	☐	________________
☐ Naproxen/Aleve	☐ (________________)	☐	________________
☐ ________________	☐ (________________)	☐	________________
☐ ________________	☐ (________________)	☐	________________
PHOTOTHERAPY	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ UVA /UVB	☐(________________)	☐	________________
☐Patient cannot afford	☐ Photosensitivity	☐Risk of Skin Cancer	☐ Distance from Office

☐Face ☐Feet ☐Groin ☐Hands
☐Nails ☐Scalp ☐Other:

Scoring tool used
☐BSA ☐EASI ☐ISGA ☐POEM
☐SCORAD _____% or Score: _____

☐ M05.9 Rheumatoid Arthritis with Rheumatoid Factor, Unspecified
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ Other: ________________________________

Date of Diagnosis: _____/_____/_______

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

Allergies:____

Additional Clinical Information:

American Academy of Dermatology Consensus Statement on Psoriasis Therapies

☐Psoriasis is covering greater than 10% of body surface area ☐ Psoriasis is on palms, soles, head and neck, or genitalia ☐ Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
☐Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment or interpersonal relationships

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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