



3712 E. Plano Parkway, Ste. 200
Plano, TX 75074
This prescription form is to be sent & received via fax

Ankylosing Spondylitis 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:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	DOB: / /	SS#:
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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
Cimzia® <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Inject 400 mg SQ at weeks 0, 2, & 4 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 400 mg SQ every 4 weeks (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 200 mg SQ every other week (Quantity: 2)	
Cosentyx® <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Sensoready® Pen <input type="checkbox"/> UnoReady® Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg SQ at week 0, 1, 2, 3, & 4 (Quantity: 5) ***Dosing intended for Non-Radiographic Axial Spondyloarthritis*** <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Quantity: 1) ***Dosing intended for Non-Radiographic Axial Spondyloarthritis*** <input type="checkbox"/> INITIAL: Inject 300 mg SQ at week 0, 1, 2, 3, & 4 (Quantity: QS 5 doses) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days)	
Enbrel® <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Min® with AutoTouch® <input type="checkbox"/> 50 mg Pre-filled Syringe	<input type="checkbox"/> Inject 50 mg SQ every week (Quantity: 4)	
Humira® Citrate Free <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Inject 40 mg SQ every other week (Quantity: 2)	
Rinvoq® 15 mg Tablets	<input type="checkbox"/> Take 15 mg PO once daily (Quantity: 30)	
Simponi® <input type="checkbox"/> SmartJect® Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Inject 50 mg SQ once a month (Quantity: 1)	
Taltz® <input type="checkbox"/> Autoinjector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg SQ at week 0 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 80 mg SQ every 4 weeks (Quantity: 1) <input type="checkbox"/> Inject 80 mg SQ every 4 weeks (Quantity: 1) ***Dosing intended for Non-Radiographic Axial Spondyloarthritis (Nr-axSpA)***	
Xeljanz® 5 mg Tablets	<input type="checkbox"/> Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR 11 mg Tablets	<input type="checkbox"/> Take 11 mg PO once daily (Quantity: 30)	

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:
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____

<input type="checkbox"/> M45.9 Ankylosing Spondylitis, Unspecified	<input type="checkbox"/> M45. _____
<input type="checkbox"/> M45.A0 Non-Radiographic Axial Spondyloarthritis (Nr-axSpA) of unspecified sites in spine	<input type="checkbox"/> M45.A _____
<input type="checkbox"/> M46.8 _____	<input type="checkbox"/> Other: _____

Date of Diagnosis: / / Allergies: _____

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

HLA-B27 Positive: 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.