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

Dermatology Injectable Enrollment Form A-D

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
Bimzelx®	☐ Pre-filled Syringe ☐ Autoinjector	☐ **INITIAL:** Inject 320 mg (two 160 mg injections) SQ on week 0, 4, 8, 12, and 16 (Quantity: 10) ☐ **MAINTENANCE:** Inject 320 mg (two 160 mg injections) SQ every 8 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 320 mg (two 160 mg injections) SQ every 4 weeks (Quantity: 2) ***Intended for patients ≥ 120 kg (264 lbs)***	
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ Inject 400 mg SQ every other week (Quantity: 4) ☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on week 0, 2, 4 (Quantity: 6) ☐ **MAINTENANCE:** Inject 200 mg SQ every **other** week starting on week 6 (Quantity: 2) ***Intended for patients ≤ 90 kg (198 lbs)***	
Cosentyx®	☐ Sensoready® Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1)	
	☐ Sensoready® Pen ☐ UnoReady® Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Quantity: QS 5 doses) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Quantity: QS 28 days) ☐ **MAINTENANCE:** Inject 300 mg SQ every 2 weeks (Quantity: QS 28 days) ***Intended for HS patients who did not adequately respond to Q4W dosing ***	
Dupixent®	☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections) at week 0 (Quantity: 2) ☐ **MAINTENANCE:** Inject 300 mg SQ every **other** week starting at day 15 (Quantity: 2)	

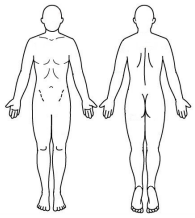
MEDICAL INFORMATION

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	☐ (_____)	☐	_____
☐ Soriatane	☐ (_____)	☐	_____
☐ Clobetasol	☐ (_____)	☐	_____
☐ 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:

☐L28.1 Prurigo Nodularis ☐L40.0 Psoriasis Vulgaris (Plaque Psoriasis)

☐ L73.2 Hidradenitis suppurativa _____ ☐ Other: _____ **Date of Diagnosis**: ____/____/_____

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

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

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.