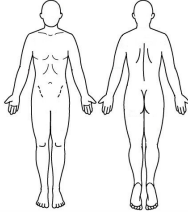
 <p>SENDERRA Specialty Pharmacy 3712 E. Plano Parkway, Ste. 200 Plano, TX 75074 <i>This prescription form is to be sent & received via fax</i></p>	Dermatology Oral/Topical Enrollment Form	Prescriber:	NPI:	
	Physician Offices Call: 855-460-7928	Supervising Physician:	NPI:	
	Fax: 888-777-5645	Address:	Tax 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? <input type="checkbox"/> Yes Start Date: / / <input type="checkbox"/> No SHIP TO: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____			
Drug		Directions & Quantity	Refills
Olumiant®	<input type="checkbox"/> 2 mg Tablet	<input type="checkbox"/> Take 2 mg PO once daily (Quantity: 30)	
	<input type="checkbox"/> 4 mg Tablet	<input type="checkbox"/> Take 4 mg PO once daily (Quantity: 30)	
Otezla®	<input type="checkbox"/> 28 Day Starter Pack	<input type="checkbox"/> Take as directed per package instructions (Quantity: 55)	
	<input type="checkbox"/> 30 mg Tablet	<input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 60)	
Sotyktu™	6 mg Tablet	<input type="checkbox"/> Take 6 mg PO once daily (Quantity: 30)	
Opzelura™	1.5 % Cream 60 gm	<input type="checkbox"/> Apply a thin layer to affected area(s) twice a day (Quantity: 1 tube)	
Vtama®	1% Cream 60 gm	<input type="checkbox"/> Apply a thin layer to affected area(s) once a day (Quantity: 1 tube)	

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:	 <p>Affected Areas</p> <input type="checkbox"/> Face <input type="checkbox"/> Feet <input type="checkbox"/> Groin <input type="checkbox"/> Hands <input type="checkbox"/> Nails <input type="checkbox"/> Scalp <input type="checkbox"/> Other: _____ PASI Score: _____ BSA _____ % SALT Score: _____
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Soriatane	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Clobetasol	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Stelara	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Humira	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Enbrel	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> _____	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:	
<input type="checkbox"/> UVA /UVB	<input type="checkbox"/> (_____)	<input type="checkbox"/>	_____	
<input type="checkbox"/> Patient cannot afford	<input type="checkbox"/> Photosensitivity	<input type="checkbox"/> Risk of Skin Cancer	<input type="checkbox"/> Distance from Office	
<input type="checkbox"/> L40.0 Psoriasis Vulgaris (Plaque Psoriasis)		<input type="checkbox"/> L63.9 Alopecia areata, unspecified		
<input type="checkbox"/> L80 Vitiligo		<input type="checkbox"/> Other: _____		
Active TB ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: / / Hep B ruled out/treated: <input type="checkbox"/> Yes <input type="checkbox"/> 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

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.