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

Pediatric Dermatology Enrollment Form A-H

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
Cosentyx®	☐ 75 mg Pre-filled Syringe	☐ **INITIAL:** Inject 75 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 75 mg SQ every 4 weeks (Quantity: 1) ***WEIGHT REQUIRED*** _____ ***Intended for weight < 50 kg/110 lbs***	
	☐ 150 mg Sensoready Pen ☐ 150 mg Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ at week 0, 1, 2, 3, and 4 (Quantity: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Quantity: 1) ***Intended for weight ≥ 50 kg/110 lbs***	
Enbrel®	☐ SureClick® Pen ☐ Mini® with AutoTouch® ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ 25 mg Vial	☐ Inject ___ mg (0.8mg/kg x ___kg SQ every week) (Quantity: QS 1 month) ***WEIGHT REQUIRED*** ***Intended for weight < 63 kg/138 lbs***	
		☐ Inject 50 mg SQ every week (Quantity: 4) ***Intended for weight ≥ 63 kg/138 lbs***	
Humira® *Citrate Free*	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ at day 1, then 80 mg on day 15 (Quantity: QS 28 days) ☐ **MAINTENANCE:** Inject 40 mg SQ every week starting at day 29 (Quantity: 4) ***WEIGHT REQUIRED*** ***Intended for weight ≥ 60 kg/132 lbs***	
	☐ Pen	☐ **MAINTENANCE:** Inject 80 mg SQ every **other** week starting at day 29 (Quantity: 2)	
	☐ Adolescent HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ at day 1, 40 mg at day 8, then 40 mg every **other** week (Quantity: QS 28 days) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ***Intended for weight 30 kg/66 lbs to <60 kg/132 lbs***	

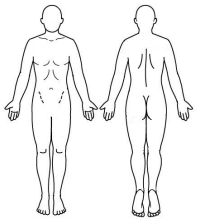
MEDICAL INFORMATION

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	☐ (_____)	☐	_____
☐ Stelara	☐ (_____)	☐	_____
☐ 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 _____%

Date of Diagnosis: ____/____/_____

☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)

☐ L73.2 Hidradenitis suppurativa

☐ Other: _____

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

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.