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

Adalimumab Biosimilar
Abrilada
Amjevita
Cyltezo
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

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
Abrilada™	☐40 mg/0.8 mL Pen ☐40 mg/0.8 mL Pre-filled Syringe ☐20 mg/0.4 mL Pre-filled Syringe	**INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** ☐**PSORIASIS/UVEITIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐**CROHN'S/UC/HS:** Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** ☐**PEDIATRIC CROHN'S:** Inject 80 mg on SQ on day 1, 40 mg on day 15, then 20 mg every other week starting on day 29 (Quantity: QS) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** **MAINTENANCE DOSES:** ☐Inject 40 mg SQ every **other** week (Quantity: 2) ☐Inject 40 mg SQ weekly (Quantity: 4) ☐Inject 80 mg SQ every **other** week (Quantity: 4) ☐Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***	
Amjevita™	☐ 40 mg/0.8 mL Sureclick® Autoinjector ☐ Pre-filled Syringe ☐ 40 mg/0.8 mL ☐ 20 mg/0.4 mL ☐ 10mg/0.2 mL	**INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** ☐**PSORIASIS/UVEITIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐**CROHN'S/UC/HS:** Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** ☐**PEDIATRIC CROHN'S:** Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: 3) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** **MAINTENANCE DOSES:** ☐Inject 40 mg SQ every **other** week (Quantity: 2) ☐Inject 40 mg SQ weekly (Quantity: 4) ☐Inject 80 mg SQ every **other** week (Quantity: 4) ☐Inject 10 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)*** ☐Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 lbs)***	
Cyltezo®	☐Psoriasis/Uveitis Starter Package ☐Crohn's/UC/HS Starter Package ☐40 mg/0.8 mL Pen ☐ Pre-filled Syringe ☐ 40 mg/0.8 mL ☐ 20 mg/0.4 mL ☐ 10mg/0.2mL	**INITIAL/LOADING DOSES:** ***WEIGHT REQUIRED_____*** ☐**PSORIASIS/UVEITIS:** Inject 80 mg on SQ day 1, 40 mg on day 8, then 40 mg every **other** week (Quantity: 4) ☐**CROHN'S/UC/HS:** Inject 160 mg on SQ on day 1, then 80 mg on day 15 (Quantity: 6) ***Intended for ped CD patients ≥ 40kg (88 lbs)*** ☐**PEDIATRIC CROHN'S:** Inject 80 mg on SQ on day 1, then 40 mg on day 15 (Quantity: 3) ***Intended for weight 17 kg (37 lbs) to < 40 kg (88 lbs)*** **MAINTENANCE DOSES:** ☐Inject 40 mg SQ every **other** week (Quantity: 2) ☐Inject 40 mg SQ weekly (Quantity: 4) ☐Inject 80 mg SQ every **other** week (Quantity: 4) ☐Inject 10 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 10 kg (22 lbs) to <15 kg (33 lbs)*** ☐Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for JIA patients 15 kg (33 lbs) to <30 kg (66 lbs) OR Crohn's disease patients 17kg (37 lbs) to less than 40 kg (88 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	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ H20.9 Iridocyclitis (Uveitis), unspecified
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
☐ L40.50 Arthropathic Psoriasis, unspecified (Psoriatic Arthritis)
☐ L73.2 Hidradenitis suppurativa
☐ M06.9 Rheumatoid Arthritis, unspecified
☐ M08.09 Unspecified juvenile RA, multiple sites (pcJIA)
☐ M45.9 Ankylosing Spondylitis, unspecified
☐ Other: _____

Date of Diagnosis: ____/____/_____ **Allergies:** _____

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

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