ASTHMA REFERRAL FORM

Phone (888) 370.1724
Fax (855) 370.0086

AMBER™ SPECIALTY PHARMACY

Patient Information PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
SSN	Allergies	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax		

Prescriber Specialty: ☐ Allergist ☐ Pulmonologist ☐ ENT ☐ Primary Care ☐ Pediatrician ☐ Dermatologist ☐ Other:

Diagnosis/Clinical Information FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA OR CIU

ICD-10-CM: ☐ J45.40 Moderate persistent asthma, uncomplicated ☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Idiopathic urticaria ☐ Other:

Concomitant therapies (check all that apply): ☐ Short acting beta agonist ☐ Long acting beta agonist ☐ Systemic glucocorticoids ☐ H1 Antihistamines ☐ Decongestants ☐ Immunotherapy ☐ Inhaled corticosteroid ☐ Leukotriene modifers ☐ Nasal steroids ☐ Proton pump inhibitor ☐ H2 antagonist ☐ Other:

Allergic Asthma: ☐ History of positive skin or RAST test to a perennial aeroallergen ☐ Symptoms inadequately controlled with ICS
Pretreatment serum IgE level: _____IU/mL Test date: _____/_____/_____
Pretreatment FEV1 (if available): _____% Date obtained: _____/_____/_____
Eosinophil levels (if available): _____cells/mcL Test date: _____/_____/_____
Number of severe exacerbations in the past 12 months _____

Chronic Idiopathic Urticaria: ☐ Patient has had CIU for 6 weeks or more

Prescription type: ☐ Naive/New Start ☐ Restart ☐ Continued Treatment ☐ Last Injection Date: / /

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **Xolair** - Allergic Asthma **Every FOUR weeks dosing.** ***(dose dependent on weight and IgE levels)***	150mg single use vials Current weight: _____kg Weight date: ____/____/____	☐ Administer 75mg/dose every 4 weeks ☐ Administer 150mg/dose every 4 weeks ☐ Administer 225mg/dose every 4 weeks ☐ Administer 300mg/dose every 4 weeks ☐ Other: Administer _____mg/dose every 4 weeks		
☐ **Xolair** - Allergic Asthma **Every TWO weeks dosing.** ***(dose dependent on weight and IgE levels)***	150mg single use vials Current weight: _____kg Weight date: ____/____/____	☐ Administer 225mg/dose every 2 weeks ☐ Administer 300mg/dose every 2 weeks ☐ Administer 375mg/dose every 2 weeks ☐ Other: Administer _____mg/dose every 2 weeks		
☐ **Xolair** - CIU **Every FOUR weeks dosing.** ***(fixed dose, not dependent on weight or IgE)***	150mg single use vials	☐ Administer 150mg/dose every 4 weeks ☐ Administer 300mg/dose every 4 weeks ☐ Other: Administer _____mg/dose every 4 weeks		
☐ **EpiPen**		Use as directed	2	
☐ **EpiPen Jr.**		Use as directed	2	

Do you require diluent and supplies? ☐ No ☐ Yes -- 10mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringe as needed for reconstitution, 18 gauge needles as needed for reconstitution; 25 gauge needles as needed for administration

Date needed: _____/_____/_____ Medication delivery to (choose one): ☐ Prescriber ☐ Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (Date)

DISPENSE AS WRITTEN/Do Not Substitute (Date)