INFLAMMATORY BOWEL DISEASE (IBD) REFERRAL FORM

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

AMBER™ SPECIALTY PHARMACY

Patient Information *Please Fax a Copy of Patient's Insurance Card (Front and Back)*

Last Name	First Name	Home Phone	Work/Mobile Phone	Date of Birth

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Gender (M/F)	Weight	Emergency Contact/Phone	Primary Caregiver/Phone

Healthcare Provider Information **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Nurse/Key Contact	Phone or Pager Number	Email

Clinical Information

Diagnosis (ICD-10): _____

Date of Diagnosis (or years with disease): _____ **Crohn's Severity:** ❑ Moderate ❑ Moderate to Severe ❑ Severe

Enterocutaneous/Recto Vaginal Fistulas? ❑ Yes ❑ No **Does patient have a latex allergy?** ❑ Yes ❑ No

Prior (FAILED) Therapy: ❑ Humira ❑ Simponi ❑ Remicade ❑ Cimzia ❑ Methotrexate ❑ Corticosteroids ❑ Immunosuppressants (6-MP or other) ❑ Surgery ❑ Other (please list): _____

TB/PPD Test Given? ❑ Yes ❑ No **Date of Negative TB test:** _____ **Hepatitis B ruled out?** ❑ Yes ❑ No **If no, has treatment been started?** ❑ Yes ❑ No

Delivery/Injection Training Information

Today's Date	Date Shipment Needed	Deliver to:	Special Instructions
		❑ Home ❑ Facility (address listed above)	

****Amber Pharmacy to coordinate injection training/home health nurse visit as necessary?** ❑ Yes ❑ No ❑ Injection Training is not necessary

❑ Medication to be administered at facility ❑ Referred to alternate trainer ❑ Patient already independent ❑ Provider office to train or has trained patient

Medication	Dose/Strength	Directions for Use	Qty	Refills
❑ **Cimzia®** **If prescribing Cimzia® vials, please document injection training information above****	**Induction Dose:** ❑ Cimzia® Starter Kit (6x200mg Prefilled Syringes) ❑ Cimzia® 2 x 200mg Lyophylized Vials (three packs)	Inject 400mg SC initially, repeat dose 2 and 4 weeks after initial dose	QS	0
	Maintenance Dose: ❑ Cimzia® 2 x 200mg Prefilled Syringes ❑ Cimzia® 2 x 200mg Lyophylized Vials	Inject 400mg SC every 4 weeks	28 day supply	
❑ **Humira®**	**Induction Dose:** ❑ Humira® Crohn's Disease/Ulcerative Colitis Starter Pack	❑ Inject 160mg (4x40mg pens) SC as a single dose on Day 1, **OR** ❑ 80mg (2x40mg pens) SC daily over 2 consecutive days; then inject 80mg (2x40mg pens) SC two weeks later (on Day 15)	#1 Starter Package (6 pens)	0
	Maintenance Dose: ❑ 40mg/0.8ml Prefilled syringe ❑ 40mg/0.8ml Pen	Inject 40mg SC every other week	2	
❑ **Remicade®**	❑ 100mg Powder Vial (Patient Weight: _____) **Drug will be dispensed to the appropriate healthcare provider**	**Induction Dose:** ❑ Infuse 5mg/kg IV at 0, 2 and 6 weeks	QS	0
		Maintenance Dose: ❑ Infuse 5mg/kg IV every 8 weeks ❑ Infuse _____ mg/kg IV every 8 weeks (dose may be increased to 10mg/kg in patients who respond but then lose their response).	QS	
❑ **Simponi®**	❑ 100mg/1ml Prefilled syringe ❑ 100mg/1ml SmartJect® Autoinjector	**Induction Dose:** ❑ Inject 200mg (2x100mg syringes/pens) SC at week 0; then inject 100mg SC at week 2	3	0
		Maintenance Dose: ❑ Inject 100mg SC every 4 weeks	1	

****When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards****

Physician Signature:_____ ❑ **DAW** (Dispense as Written) **Date** ____/____/____