LUPUS 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 INSURANCE CARD (FRONT AND BACK)

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

Prescriber Information

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

Diagnosis/Clinical Information

ICD-10-CM: ☐ M32.10 Systemic lupus erythematosus ☐ M32.9 Systemic lupus erythematosus, unspecified ☐ Other:

Patient previously treated for lupus: ☐ No ☐ Yes

Previous therapies: _____

Current therapies: _____

Medication list:

Pre-medications (to be taken _____minutes prior to infusion):

Drug	Strength	Directions	QTY	Refill

Site of care for patient: ☐ Office ☐ Infusion center ☐ Home health agency

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **Benlysta** (Initial Dosing) (belimumab) Current weight: _____kg	☐ 120mg (5mL vial) ☐ 400mg (20mL vial)	**Initial dosing:** ☐ Infuse 10mg/kg IV over one hour every 2 weeks for first 3 doses Total dose: _____mg	QS	0
☐ **Benlysta** (Maintenance Dosing) (belimumab) IV Administration Current weight: _____kg	☐ 120mg (5mL vial) ☐ 400mg (20mL vial)	**Maintenance dosing:** ☐ Infuse 10mg/kg IV over one hour every 4 weeks Total dose: _____mg	QS	
☐ **Benlysta** (Maintenance Dosing) (belimumab) SC Administration Current weight: _____kg	☐ 200mg/mL PFS ☐ 200mg/mL Autoinjector	☐ Inject 200mg SC once weekly	28 day supply	

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)

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.