ONCOLOGY REFERRAL FORM

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

AMBER™ SPECIALTY PHARMACY

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Date of Birth	Gender (M/F)	Weight	Diagnosis

Special Instructions (allergies, language preference, etc.)

Primary Caregiver/Phone	Emergency Contact/Phone

Healthcare Provider Information: **Indicates Required Field*

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

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

Physician NPI#*	Physician DEA#	Physician State License #	Physician UPIN#

Nurse/Key Contact	Phone or Pager Number	Email

Insurance Information *Fill out entirely OR fax a copy of patient's insurance card - both sides*

Primary Insurance	Phone	Name/SSN of Insured	ID Number	Group Number
Secondary Insurance	Phone	Name/SSN of Insured	ID Number	Group Number

Other Insurance/Prescription Drug Vendor (Rx Bin #)

Additional Information

Today's Date	Date Meds Needed	May we contact this patient?	Primary ICD-9 Code
		☐ Yes ☐ No	

Medication	Dose/Strength	Directions for Use	Quantity	Refills
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

*****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** ____ /____ /____