OTEZLA®
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	Gender (M/F)	Weight	Date of Birth	Allergies

Emergency Contact	Phone	Primary Caregiver	Phone

Primary Diagnosis

❑ ICD-10 L40.50 (psoriatic arthritis) ❑ ICD-10 L40.0 (psoriasis) ❑ Other:

Current or most recent therapy (include dates/duration)

❑ No prior disease modifying therapies

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

Healthcare Provider Information: **Indicates Required Field*

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

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

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

Nurse/Key Contact	Phone or Pager Number	Email

Otezla®

❑ **Otezla® Rx**

30mg ❑ TWICE Daily ❑ ONCE Daily x30 days _____ Refills Date titration sample provided to patient: ____ /____ /____

Special instructions: _____

❑ **Bridge Rx – 14 days***

❑ 30mg TWICE Daily x14 days 28 tablets 4 Refills

❑ 30mg ONCE Daily x28 days 28 tablets 2 Refills

*Bridge Rx is at no cost, for commercially insured patients only, and not contingent on purchase requirements of any kind. Enrollees in Medicare, Medicaid, and other federal and state programs, as well as Minnesota and Massachusetts residents are not eligible. Intended to promote patient access to prescribed therapy if there is a delay in determining whether commercial prescription coverage is available.

❑ **Titration Starter Pack - 28 days**

Take as Directed x28 days 55 tablets 0 Refills

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

Physician Signature:_____ (Dispense as Written) **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.