

OTEZLA®
REFERRAL FORM

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



Patient Information					
Last Name		First Name		Home Phone	Work/Mobile Phone
Home Address				City	State
Shipping Address (if different from above)				City	State
Social Security Number	Gender (M/F)	Weight	Date of Birth	Allergies	
Emergency Contact		Phone		Primary Caregiver	Phone
Primary Diagnosis <input type="checkbox"/> ICD-10 L40.50 (psoriatic arthritis) <input type="checkbox"/> ICD-10 L40.0 (psoriasis) <input type="checkbox"/> Other:			Current or most recent therapy (include dates/duration)		
			<input type="checkbox"/> No prior disease modifying therapies		

Insurance Information <i>Fill out entirely OR fax a copy of patient's insurance card - both sides</i>				
Primary Insurance		Phone	Name/SSN of Insured	ID Number
Secondary Insurance		Phone	Name/SSN of Insured	ID 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®	
<input type="checkbox"/> Otezla® Rx 30mg <input type="checkbox"/> TWICE Daily <input type="checkbox"/> ONCE Daily x30 days _____ Refills Date titration sample provided to patient: ____/____/____ Special instructions: _____	
<input type="checkbox"/> Bridge Rx - 14 days* <input type="checkbox"/> 30mg TWICE Daily x14 days 28 tablets 4 Refills <input type="checkbox"/> 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.	
<input type="checkbox"/> 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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.