TRANSPLANT REFERRAL FORM

AMBER™ SPECIALTY PHARMACY

PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT	
Primary Caregiver Name (If applicable)		
Caregiver Email		Caregiver Phone
Alternate Contact Name		
Alternate Contact Email		Alternate Contact Phone

PRESCRIBER INFORMATION

Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber Specialty		
Prescriber State License #		DEA #
NPI #		Medicaid UPIN #
Office Contact Name		Title
Office Email		
Office Phone	Office Fax	
Preferred Contact Method (check one)	☐ Email ☐ Phone ☐ Fax	Best Time to Call

INSURANCE INFORMATION

Insurance Provider		Plan ID #
BIN#:	PCN#:	RX Group#:
Insured's Name		Relationship to Patient

Eligible for Medicare (check one)	☐ Yes ☐ No	If yes, list Medicare #
Prescription Card (check one)	☐ Yes ☐ No	If yes, list carrier

Please include a copy of the front and back of insurance card.

CLINICAL INFORMATION

Prescription Type (check one)	☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date
Sample/Starter Product Provided? (check one) ☐ Yes ☐ No	If yes, Provide Qty	Sample Date Provided
Date of Transplant	Date of Discharge	Date Medication Needed
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	Allergies (check one) ☐ NKDA ☐ Drug Allergies (please list)	

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	
Ship to Address (check one)	☐ Home ☐ Prescriber's Office ☐ Other (please list)		
Other/Concomitant Medications			
ICD-10 Codes	☐ Kidney (Z94.0) ☐ Heart (Z94.1) ☐ Heart/Lung (Z94.3) ☐ Bone Marrow (Z94.81) ☐ Pancreas (Z94.83)	☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Lung (Z94.2) ☐ Liver (Z94.4) ☐ Intestines (Z94.82)	

We accept Escribe and fax prescriptions. A faxable presciption form is attached.

P 855.896.9254 | **F** 877.645.7514 | 10004 S. 152nd St, Suite A, Omaha NE 68138

TRANSPLANT PRESCRIPTIONS

MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER FOR OFFICIAL PATIENT RECORDS)

Patient Last Name	Patient First Name	DOB
Address		
City	State	ZIP
Date of Issue		

Prescriber Name		
Prescriber Address		
City	State	ZIP
NPI #	DEA #	

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS

_____ ☐ _____ _____ /_____ /_____

Prescriber Signature | DAW (Dispense as Written) | Date

_____ _____ /_____ /_____

Supervising Physician Signature (where required by state law) | Date

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 substitutions: _____