ASTHMA 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/Alt Contact Name (If applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

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

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

Allergic Asthma
☐ History of positive skin or RAST test to a perennial aeroallergen
☐ Symptoms inadequately controlled with ICS
Pretreatment serum IgE level _____IU/mL Test date ____/____/____
Pretreatment FEV1 (if available) _____% Date obtained ____/____/____
Eosinophil levels (if available) _____cells/mcL Test date ____/____/____
Number of severe exacerbations in the past 12 months _____

Chronic Idiopathic Urticaria ☐ Patient has had CIU for 6 weeks or more	Therapies Tried and Failed (please list medications)

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Other/Concomitant Medications		
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	

ICD-10 Codes
☐ J45.4 Moderate Persistent Asthma
☐ J45.5 Severe Persistent Asthma
☐ D72.119 Hypereosinophilic Syndrome (HES)
☐ M30.1 Eosinophilic Granulomatosis with Polyangiitis (EPGA)
☐ J33.0 Polyp of the Nasal Cavity
☐ J33.1 Polypoid Sinus Segeneration
☐ J33.8 Other Polyp of the Sinus
☐ J33.9 Nasal Polyp, Unspecified (indication for dupilumab and omalizumab)
☐ J82 Pulmonary Eosinophilia
☐ L50.1 Idiopathic Urticaria
☐ Other Code _____
Description _____
☐ Date of Diagnosis ____/____/____

We accept Escribe and fax prescriptions.

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

REV.0421

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		

Practice / Facility Name		
Practice Address		
City	State	ZIP
NPI #	DEA #	

PRESCRIPTION INFORMATION

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. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS	DAW (Dispense as Written)
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

Total RXs _____

_____ _____ /_____ /_____

Prescriber Signature Date

_____ _____ /_____ /_____

Supervising Physician Signature (where required by state law) Date

The information contained in this document will become a legal prescription.* ***Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. *If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.*