BREAST CANCER 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)	
Failed Therapies (Please also attach recent labs/clinical notes)		
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	

Height (cm/in)	Weight (kg/lbs)	BSA	Date Obtained
Concurrent Medications			
BRCA Mutation	☐ Positive ☐ Negative ☐ N/A		
Estrogen Receptor Status	☐ Positive ☐ Negative ☐ N/A		
HER2 Status	☐ Positive ☐ Negative ☐ N/A		
Progesterone Receptor Status	☐ Positive ☐ Negative ☐ N/A		
Is patient post menopausal	☐ Yes ☐ No		

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

BREAST CANCER REFERRAL FORM

AMBER™ SPECIALTY PHARMACY

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 #	

CLINICAL INFORMATION CONTINUED

ICD-10 Codes

Right Female Breast
- ☐ C50.011 malignant neoplasm of nipple and areola
- ☐ C50.111 malignant neoplasm of central portion
- ☐ C50.211 malignant neoplam of upper-inner quadrant
- ☐ C50.311 malignant neoplasm of lower-inner quadrant
- ☐ C50.411 malignant neoplasm of upper-outer quadrant
- ☐ C50.511 malignant neoplasm of lower-outer quadrant
- ☐ C50.611 malignant neoplasm of axillary tail
- ☐ C50.811 malignant neoplasm of overlapping sites
- ☐ C50.911 malignant neoplasm of unspecified site
- ☐ D05.01 lobular carcinoma in situ
- ☐ D05.11 intraductal carcinoma in situ
- ☐ D05.81 other specified type of carcinoma in situ

Left Female Breast
- ☐ C50.012 malignant neoplasm of nipple and areola
- ☐ C50.112 malignant neoplasm of central portion
- ☐ C50.212 malignant neoplam of upper-inner quadrant
- ☐ C50.312 malignant neoplasm of lower-inner quadrant
- ☐ C50.412 malignant neoplasm of upper-outer quadrant
- ☐ C50.512 malignant neoplasm of lower-outer quadrant
- ☐ C50.612 malignant neoplasm of axillary tail
- ☐ C50.812 malignant neoplasm of overlapping sites
- ☐ C50.912 malignant neoplasm of unspecified site
- ☐ D05.02 lobular carcinoma in situ
- ☐ D05.12 intraductal carcinoma in situ
- ☐ D05.82 other specified type of carcinoma in situ

ICD-10 Codes

Right Male Breast
- ☐ C50.021 malignant neoplasm of nipple and areola
- ☐ C50.121 malignant neoplasm of central portion
- ☐ C50.221 malignant neoplam of upper-inner quadrant
- ☐ C50.321 malignant neoplasm of lower-inner quadrant
- ☐ C50.421 malignant neoplasm of upper-outer quadrant
- ☐ C50.521 malignant neoplasm of lower-outer quadrant
- ☐ C50.621 malignant neoplasm of axillary tail
- ☐ C50.821 malignant neoplasm of overlapping sites
- ☐ C50.921 malignant neoplasm of unspecified site
- ☐ D05.01 lobular carcinoma in situ
- ☐ D05.11 intraductal carcinoma in situ
- ☐ D05.81 other specified type of carcinoma in situ

Left Male Breast
- ☐ C50.022 malignant neoplasm of nipple and areola
- ☐ C50.122 malignant neoplasm of central portion
- ☐ C50.222 malignant neoplam of upper-inner quadrant
- ☐ C50.322 malignant neoplasm of lower-inner quadrant
- ☐ C50.422 malignant neoplasm of upper-outer quadrant
- ☐ C50.522 malignant neoplasm of lower-outer quadrant
- ☐ C50.622 malignant neoplasm of axillary tail
- ☐ C50.822 malignant neoplasm of overlapping sites
- ☐ C50.922 malignant neoplasm of unspecified site
- ☐ D05.02 lobular carcinoma in situ
- ☐ D05.12 intraductal carcinoma in situ
- ☐ D05.82 other specified type of carcinoma in situ

Personal or Family History
- ☐ Z85.3 Personal history of malignant neoplasm of breast
- ☐ Z80.3 Family history of malignant neoplasm of breast

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PRESCRIPTIONS

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

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Address		
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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.*