RESPIRATORY SYNCYTIAL VIRUS 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
Allergies ☐ NKDA ☐ Drug Allergies (please list)		
Nursing ☐ No nursing coordination ☐ Yes, Amber Specialty Pharmacy to coordinate home health nurse visit for injection		
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	Needs by Date
		Expected Date of First Injection
Other/Concomitant Medications		

Patient's Gestational Age	Weeks Days	Birth Weight (g/kg/lbs)
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Did Patient Receive Synagis Last Season? ☐ No ☐ Yes		If Yes, List Date
Multiple Births ☐ Yes ☐ No	Attending Daycare ☐ Yes ☐ No	School-age Siblings in Home ☐ Yes ☐ No

ICD-10 Codes

- ☐ <23 completed weeks (P07.21)
- ☐ 23 completed weeks (P07.22)
- ☐ 24 completed weeks (P07.23)
- ☐ 25 completed weeks (P07.24)
- ☐ 26 completed weeks (P07.25)
- ☐ 27 completed weeks (P07.26)
- ☐ 28 completed weeks (P07.31)
- ☐ 29 completed weeks (P07.32)
- ☐ 30 completed weeks (P07.33)
- ☐ 31 completed weeks (P07.34)
- ☐ 32 completed weeks (P07.35)
- ☐ 33 completed weeks (P07.36)
- ☐ 34 completed weeks (P07.37)
- ☐ 35 completed weeks (P07.38)

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

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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

NICU History

Did the patient spend time in the NICU? ☐ Yes ☐ No
If yes, please attach the NICU Discharge Summary

Was there a NICU/Hospital RSV dose administered ☐ Yes ☐ No
If Yes, List Date

Medical Criteria for RSV Prophylaxis

☐ Prematurity
Less than 12 months at start of RSV season and <28 weeks 6 days gestational age

Chronic Respiratory Disease Arising in the Perinatal Period

(check all that apply)
☐ Wilson-Mikity Syndrome (P27.0)
☐ Bronchopulmonary Dysplasia originating in the perinatal period (P27.1)
☐ Other chronic respiratory disease originating in the perinatal period (P27.8)

Congenital Abnormality of the Respiratory System

(check all that apply)
☐ Congenital Subglottic Stenosis (Q31.1)
☐ Other congenital malformations of Trachea (Q32.1)
☐ Laryngocele (Q31.3)
☐ Other congenital malformations of Bronchus (Q32.4)
☐ Other congenital malformations of Larynx (Q31.8)
☐ Congenital Cystic Lung

Chronic Lung Disease (CLD)

(check all that apply)
☐ Yes ☐ No Diagnosis of CLD < 12 months of age ICD-10 _____
☐ Yes ☐ No Gestational Age ≤31 weeks, 6 days ICD-10 _____
☐ Yes ☐ No Patient required >21% oxygen for at least the first 28 days after birth
☐ Yes ☐ No Patient is 12 to 24 months of age, meets all CLD requirements above, and continues to require medical support for CLD within 6 months of the start of RSV season

(check all that apply and last date received):

☐ Supplemental Oxygen (dates) _____
☐ Corticosteroids (dates) _____
☐ Diuretic therapy (dates) _____
☐ Bronchodilators (dates) _____

Congenital Heart Disease (CHD)

Patient is 12 months of age or younger with hemodynamically significant congenital heart disease
☐ Yes ☐ No

Patient has the following condition(s)
☐ Diagnosis of moderate-severe pulmonary hypertension ICD-10 _____
☐ Cyanotic heart disease (in consultation with a pediatric cardiologist)
ICD-10 _____
☐ Acyanotic heart disease (receiving medication to control CHF and will require cardiac surgical procedures:
ICD-10 _____
CHF meds/dates _____
Surgery Date _____

Patient is younger than 24 months of age and has undergone cardiac transplantation during the RSV season ☐ Yes ☐ No
Date of Transplant

Neuromuscular/Airway Conditions

Patient has neuromuscular disease/congenital airway abnormality with impaired ability to clear secretions from upper airway during first year of life
☐ Yes ☐ No

☐ Severe Neuromuscular disease ICD-10 _____
☐ Congenital or other pulmonary abnormality ICD-10 _____

Immune Disorder

Profoundly immunocompromised during the RSV season, including but not limited to cardiac or other transplant, chemotherapy, primary immune disorder, etc.
☐ Yes ☐ No

ICD-10 _____
Condition and Drug Regimen _____

Cystic Fibrosis

Patient has a diagnosis of Cystic Fibrosis
☐ Yes ☐ No

As well as (check all that apply)
☐ Clinical evidence of CLD (under 12 months of age)
☐ Nutritional compromise (under 12 months of age)
☐ Manifestations of severe lung disease (12-24 months of age) *(previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable)
☐ Weight for length less than 10th percentile (12-24 months of age)

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PRESCRIPTIONS

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

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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.*