IMMUNOLOGY INFUSION 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
Allergies ☐ NKDA ☐ Drug Allergies (please list)		
Therapies Tried and Failed (please list medications)		
Concurrent Medications		

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	
ICD-10 Codes	☐ D80.0 Congenital Hypogam ☐ D83.9 CVID (unspecified) ☐ D81.9 SCID (unspecified) ☐ Other _____	

We accept Escribe and fax prescriptions.

Phone 855.896.9254 | **Fax** 855.370.0086

REV.0421

PRESCRIPTIONS

Patient Last Name	Patient First Name	DOB

PRESCRIPTION INFORMATION

MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Asceniv™ 10% ☐ Bivigam® 10% ☐ Gammagard® liquid 10% ☐ Gammagard® S/D 5% ☐ Gammagard® S/D 10% ☐ Gammaked™ 10% ☐ Gammaplex® 5% ☐ Gammaplex® 10% ☐ Gamunex® C 10% ☐ Hizentra 20% ☐ Octagam® 10% ☐ Panzyga® 10% ☐ Privigen® 10% ☐ Xembify	☐ Peripheral ☐ Central ☐ Port ☐ Subcutaneous	Infuse _____ grams OR _____ grams per kg OR _____ mgper kg intravenously every _____ weeks Divide total dose over _____ days (where clinically appropriate, round to the nearest vial size)	Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling Infusion method: ☐ Gravity ☐ Pump	☐ 3 months ☐ 6 months ☐ 1 year	
☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 500 mg ☐ 650 mg ☐ 1 gm ☐ _____	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:	☐ _____				
☐ Vascular Access Method	☐ peripheral ☐ central ☐ other: _____				

Total RXs _____

Lab Orders _____

Skilled nursing visits as needed to establish venous access administer medication and assess general status and response to therapy. Dispense 1 month of drug, flushes, needles, syringes, ancillary supplies and medical equipment necessary to establish access and administer medication. Prescription to include all necessary ancillary supplies (needle, syringes, etc). If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted support program.

_____ _____ /_____ /_____ _____

Patient Signature | Date | Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting.)

_____ _____ /_____ /_____

Prescriber Signature | Date

_____ _____ /_____ /_____

Supervising Physician Signature (Dispense as Written) | 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.*