MULTIPLE SCLEROSIS 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 (If NOT Neurologist, include neurology consult if available)		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

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
Date of Diagnosis or Years with Condition	Is Patient currently on MS therapy ☐ Yes ☐ No	If yes, please list
Will patient be stopping above medication before starting new therapy? ☐ Yes ☐ No		If yes, list date
Past Meds Tried/Failed (please list)		
If female, is patient pregnant, nursing or planning pregnancy? ☐ Yes ☐ No ☐ N/A (e.g., menopause)		
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)	
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	

Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Other/Concomitant Medications		
Type of Multiple Sclerosis ☐ Relapsing ☐ Progressive Relapsing ☐ Primary Progressive ☐ Secondary Progressive (SPMS) ☐ Clinically Isolated Syndrome		
Last MRI Date	Does MRI show features consistent with MS? ☐ Yes ☐ No	
Any MRI changes? ☐ Yes ☐ No	If yes, please list	
Is the patient's functional status ambulatory? ☐ Yes ☐ No	Number of relapses in past year	
For Dalfampridine; 25-foot timed walking test (T25-FW)	seconds/minutes	seconds/minutes
ICD-10 Codes ☐ G35 Multiple Sclerosis ☐ Other _____		

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.*