ASTHMA & ALLERGY REFERRAL FORM (A-F)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER™ SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	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)	Alt Contact Email	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	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment — Therapy Start Date

Therapies Tried and Failed (please list medications)

Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided: — Patient Height (cm/in): Weight (kg/lbs): Date Obtained:

If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No — Patient has had Chronic Idiopathic Urticaria for 6 weeks or more ☐ Yes ☐ No

Other/Concomitant Medications (please list)

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 _____

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

ICD-10 Code ☐ Code _____ Description _____ ☐ Code _____ Description _____
☐ Date of Diagnosis _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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
☐ Cinqair	☐ 10 mg/ml	☐ 3mg/kg IV infusion over 20 to 50 minutes every 4 weeks		
☐ Dupixent	PFS ☐ 100 mg/0.67 ml PFS ☐ 200 mg/1.14 ml PFS ☐ 300 mg/2ml PFS PEN ☐ 200 mg/1.14 ml pre-filled pen* ☐ 300 mg/2 ml pre-filled pen* *comes in cartons of 2	Pediatric 15 to <30kg: ☐ Inject 100 mg SC (one injection) every other week ☐ Inject 300 mg SC (one injection) every four weeks Pediatric ≥30 kg: ☐ Inject 200 mg SC (one injection) every other week Adult Initial Dose: ☐ Inject 400 mg SC (2-200 mg injections in different injection sites) initially then 200 mg SC every other week ☐ Inject 600 mg SC (2-300 mg injections in different injection sites) initially then 300 mg SC every other week Adult Maintenance Dose: ☐ Inject 200 mg (one injection) SC every other week ☐ Inject 300 mg (one injection) SC every other week Chronic Sinusitis with Nasal Polyposis: ☐ Inject 300 mg (one injection) SC every other week Other: ☐ _____		
☐ Fasenra	☐ 30 mg/ml Auto-Injector ☐ 30 mg/ml PFS	Adults and Pediatrics (age 12 or greater) – 30mg subcutaneously once every 4 weeks for the first 3 doses, and then once every 8 weeks		

_____ _____ _____ _____
Prescriber Signature | Date | Supervising Physician Signature (where required by state law) | Date

_____ _____ _____
DAW (Dispense as Written) | Date | Brand Necessary (must handwrite)

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV1221

ASTHMA & ALLERGY REFERRAL FORM (G-Z)

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AMBER™ SPECIALTY PHARMACY

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Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	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	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date

Therapies Tried and Failed (please list medications)

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Xolair Every FOUR weeks dosing. (dose dependent on weight and IgE levels)	VIAL ☐ 150 mg vial kit PFS ☐ 75 mg/0.5 ml ☐ 150 mg/0.5 ml ☐ To be administered by a Healthcare Professional ☐ Shipping to Home: Has patient received at least 3 doses of Xolair under the guidance of a healthcare provider with no hypersensitivity reaction? ☐ Yes ☐ No	Every 4 weeks dosing: ☐ Administer 75 mg per dose subcutaneously every 4 weeks ☐ Administer 150 mg per dose subcutaneously every 4 weeks ☐ Administer 225 mg per dose subcutaneously every 4 weeks ☐ Administer 300 mg per dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 4 weeks Every 2 weeks dosing: ☐ Administer 225 mg per dose subcutaneously every 2 weeks ☐ Administer 300 mg per dose subcutaneously every 2 weeks ☐ Administer 375 mg per dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 2 weeks		
☐ EpiPen		☐ Use as directed		
☐ EpiPen Jr.		☐ Use as directed		

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

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