DIABETIC SUPPLY REFERRAL FORM

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
Patient's Diabetes Type ☐ Type 1 (E10.9) ☐ Type 2 (E11.9) ☐ Drug or chemical induced diabetes mellitus **without** complications (E09.9) ☐ Drug or chemical induced diabetes mellitus **with** unspecified complications (E09.8)	
Patient's Insulin Status Type ☐ Non-Insulin-dependent ☐ Insulin-dependent	Patient is currently taking as part of their diabetes management regimen.
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in): Weight (kg/lbs): Date Obtained:
Other/Concomitant Medications (please list)	
Allergies ☐ NKDA ☐ Drug Allergies (please list)	☐ Other Allergies (please list)

PRESCRIPTION/ORDER 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.

Before selecting a testing frequency, please note the following insurance limitations:

- Non-insulin Dependent: Per CMS guidelines >100 test strips or lancets every 3 months requires medical justification
- Insulin Dependent: Per CMS guidelines >300 test strips or lancets every 3 months requires medical justification

Testing Frequency: ☐ 1x/day ☐ 2x/day* ☐ 3x/day* ☐ 4x/day* ☐ Other: _____

- Refills are valid for a maximum of 6 months
- Frequency of use information on prescriptions must contain detailed instructions for use and specific amounts to be dispensed. Orders that only state "PRN, as needed or only per sliding scale" utilization estimates for replacement frequency, use, or consumption are not acceptable

Brand dispensed is based on insurance formulary with quantities sufficient for 30 days & includes:

HCPCS Code	Item	DIRECTIONS	QTY
☐ E0607	Home Blood Glucose Meter	Use for testing of blood sugars	1
☐ A4258	Spring-powered Device for Lancet	For use with lancets	1
☐ A4256	Normal, Low High Calibrator Solution/chips	Use to check integrity of test strips	1
☐ A4253	Blood Glucose Test Strips	Use to test blood glucose	See Testing Frequency
☐ A4259	Lancets	Use to collect blood sample	See Testing Frequency

Medical Justification:** Required if testing: ***Attach clinic notes within the last 6 months justifying the frequency of testing.

☐ Uncontrolled Blood Glucose
☐ Insulin Pump Therapy
☐ Sliding Scale Insulin Therapy
☐ Other: _____

Length of need for therapy: _____

_____ _____ _____ _____

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.*

REV.0222