TRANSPLANT REFERRAL FORM (Page 1 of 2)

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

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment			
Therapy Start Date	Date of Transplant	Date of Discharge	Date Medication Needed
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other (please list)			
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	

ICD-10 Codes ☐ Kidney (Z94.0) ☐ Kidney/Pancreas (Z94.0/Z94.83) ☐ Heart (Z94.1) Lung (Z94.2) ☐ Heart/Lung (Z94.3) ☐ Liver (Z94.4) ☐ Bone Marrow (Z94.81) ☐ Intestines (Z94.82) ☐ Pancreas (Z94.83) ☐ B25 CMV disease ☐ B25.9 CMV disease, unspecified ☐ Other Code _____ Description _____

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
IMMUNOSUPPRESSANTS				
☐ Azathioprine	☐ 50 mg tablet ☐ 50 mg/mL cmpd susp			
☐ Cyclosporine modified	☐ 25 mg ☐ 100 mg capsule ☐ 100 mg/mL solution (unbreakable bottle of 50 mL)			
☐ Everolimus	☐ 0.25 mg tablet ☐ 1 mg tablet ☐ 0.5 mg tablet ☐ 2.5 mg tablet ☐ 0.75 mg tablet ☐ 5 mg tablet			
☐ Mycophenolate	☐ 250 mg capsule ☐ 500 mg tablet ☐ 200 mg/mL suspension (unbreakable bottle of 160ml)			
☐ Mycophenolic acid	☐ 180 mg tablet ☐ 360 mg tablet			
☐ Nulojix (belatacept)	☐ 250 mg vial			
☐ Prednisone	☐ 1 mg tablet ☐ 10 mg tablet ☐ 2.5 mg tablet ☐ 20 mg tablet ☐ 5 mg tablet ☐ 5mg/mL solution			
☐ Prednisolone	☐ 5 mg/mL solution ☐ 5 mg/5 mL solution ☐ 15 mg/5 mL solution			
☐ Prograf granules	☐ 0.2 mg ☐ 1 mg			
☐ Sirolimus	☐ 0.5 mg tablet ☐ 1 mg/mL solution (unbreakable bottle of 60 mL) ☐ 1 mg tablet ☐ 2 mg tablet			

Total RXs _____

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

TRANSPLANT REFERRAL FORM (Page 2 of 2)

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AMBER™ SPECIALTY PHARMACY

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MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER)

Patient Last Name	Patient First Name	DOB	Date of Issue
Patient Address	City	State	ZIP
Prescriber Name	NPI #	DEA #	
Prescriber Address	City	State	ZIP

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
IMMUNOSUPPRESSANTS CONTINUED				
☐ Envarsus XR (Tacolimus ER)	☐ 0.75 mg tablet ☐ 4 mg tablet ☐ 1 mg tablet			
☐ Tacrolimus IR	☐ 0.5 mg capsule ☐ 1 mg capsule ☐ 5 mg capsule ☐ 0.5 mg/mL cmpd susp			
ANTIFUNGALS				
☐ Clotrimazole	☐ 10 mg troche			
☐ Fluconazole	☐ 100 mg tablet ☐ 150 mg tablet ☐ 200 mg tablet ☐ 10 mg/mL suspension (unbreakable bottle of 35 mL)			
☐ Nystatin	☐ 100,000 u/mL suspension			
ANTIVIRALS				
☐ Livtencity™	☐ 200 mg Tablet Post-transplant CMV infection refractory to current treatment? ☐ Yes ☐ No Anticipated Treatment Length: _____ weeks	STANDARD DOSE ☐ Take two tablets (400 mg) by mouth twice daily, with or without food ADJUSTED DOSING (PER LIVTENCITY PRESCRIBING INFORMATION, ADJUSTED DOSING IS RECOMMENDED FOR THE FOLLOWING CONCOMITANT MEDICATIONS): Carbamazepine ☐ Take four tablets (800 mg) by mouth twice daily, with or without food Phenobarbital ☐ Take six tablets (1,200 mg) by mouth twice daily, with or without food Phenytoin ☐ Take six tablets (1,200 mg) by mouth twice daily, with or without food		
☐ Valganciclovir	☐ 450 mg tablet ☐ 50 mg/mL solution (unbreakable bottle of 88 mL)			
PCP PROPHYLAXIS/ANTIBIOTICS				
☐ Ciprofloxacin	☐ 250 mg tablet ☐ 500 mg tablet ☐ Cipro 250 mg/5 mL suspension (unbreakable bottle of 100 mL)			
☐ Dapsone	☐ 25 mg tablet ☐ 100 mg tablet ☐ 2 mg/mL cmpd suspension			
☐ SMZ/trimethoprim	☐ 400 mg/80 mg SS ☐ 800 mg/160 mg DS ☐ 200 mg/40 mg/5 mL susp			
MISCELLANEOUS				
☐ Other _____				
☐ Other _____				
WELCOME KIT				
☐ Standard Kit	Includes: Lip balm, Sunscreen, Lotion, Tote Bag, Thermometer, Pill Box			
☐ Add Ons	Select up to 2: ☐ Scale ☐ Blood Pressure Monitor ☐ Blood Glucose Monitoring Kit			

Total RXs _____

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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