ASTHMA & ALLERGY REFERRAL FORM (A-D)

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) — ☐ History of positive skin or RAST test to a perennial aeroallergen

Allergies ☐ NKDA ☐ Drug Allergies (please list) — ☐ Other Allergies (please list)

Pretreatment serum IgE level _____IU/mL Test date _____ — Eosinophil levels (if available) _____cells/mcL Test date _____
Pretreatment FEV1 (if available) _____% Date obtained _____ — Number of severe exacerbations in the past 12 months _____

Initial Treatment – Classification of asthma as uncontrolled or inadequately controlled as defined by:
☐ Poor symptom control ☐ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
☐ Asthma-related emergency treatment ☐ Airflow limitation ☐ Currently dependent on oral corticosteroids for treatment of asthma

Ongoing Treatment – Positive response to treatment demonstrated by:
☐ Reduction in frequency and/or severity of relapses ☐ Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant
☐ Disease remission ☐ Reduction in severity or frequency of EGPA-related symptoms

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

ICD-10 Code ☐ Code _____ Description _____

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Cinqair *Asthma, severe eosinphilic*	☐ 100 mg/mL Vial	☐ Infuse _____ mg (3 mg/kg x _____ kg) IV once every 4 weeks	28 Day	_____
☐ Dupixent *Moderate-to-severe asthma*	Patients aged >12 years ☐ 200 mg/1.14 mL PFS ☐ 200 mg/1.14 mL PEN	☐ Initial Dose: Inject 400 mg (2x200 mg) injections SubQ on Day 1 and 200 mg SubQ on Day 15	3	0
		☐ Maintenance Dose: Inject 200 mg SubQ every 2 weeks	2	_____
	Patients aged >12 years ☐ 300 mg/2 mL PFS ☐ 300 mg/2 mL PEN	☐ Initial Dose: inject 600 mg (2x300 mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15	3	0
		☐ Maintenance Dose: Inject 300 mg SubQ every 2 weeks	2	_____
	Patients aged 6-11 years (Weight: _____kg (1 kg = 2.2 lb) Weight 15 kg to <30 kg ☐ 100 mg/0.67 mL PFS ☐ 300 mg/2 mL PFS	☐ Inject 100 mg SubQ every 2 weeks	2	_____
		☐ Inject 300 mg SubQ every 4 weeks	1	_____
	Patients aged 6-11 years (Weight: _____kg (1 kg = 2.2 lb) Weight >30 kg ☐ 200 mg/1.14 mL PFS	☐ Inject 200 mg SubQ every 2 weeks	2	_____

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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REV1102223

ASTHMA & ALLERGY REFERRAL FORM (D)

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AMBER SPECIALTY PHARMACY

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Allergies ☐ NKDA ☐ Drug Allergies (please list) | ☐ Other Allergies (please list)

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Initial Treatment – Classification of asthma as uncontrolled or inadequately controlled as defined by:
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Ongoing Treatment – Positive response to treatment demonstrated by:
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☐ Dupixent *Oral CS-dependent asthma or co-morbid AD or adults with co-morbid rhinosinusitis w/nasal polyps*	Patients aged >12 years ☐ 300 mg/2 mL PFS ☐ 300 mg/2 mL PEN	☐ Initial Dose: Inject 600 mg (2x300 mg) injections on Day 1 and 300 mg SubQ on Day 15	3	0
		☐ Maintenance Dose: Inject 300 mg SubQ every 2 weeks	2	_____
	Patients aged 6-11 years (Weight: _____ kg (1 kg = 2.2 lb) ☐ 300 mg/2 mL PFS	☐ Initial Dose: Inject 600 mg (2x300mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15	3	0
		☐ Maintenance Dose: Inject 300 mg SubQ every 4 weeks	1	_____
	Weight 30 kg to <60 kg ☐ 200 mg/1.14 mL PFS	☐ Initial Dose: Inject 400 mg (2x200mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15	3	0
		☐ Maintenance Dose: Inject 200 mg SubQ every 2 weeks	2	_____
	Weight >60 kg ☐ 300 mg/2 mL PFS	☐ Initial Dose: Inject 600 mg (2x300mg) injections SubQ on Day 1 and 300 mg SubQ on Day 15	3	0
		☐ Maintenance Dose: Inject 300 mg SubQ every 2 weeks	2	_____
☐ Dupixent *Chronic rhinosinusitis w/nasal polyposis*	☐ 300 mg/2 mL PFS ☐ 300 mg/2 mL PEN	☐ Inject 300 mg SubQ every 2 weeks	2	_____
☐ Fasenra *Asthma, severe eosinphilic*	☐ 30 mg/mL PFS	☐ Office-Administered Loading Dose: Inject 30 mg SubQ once every 4 weeks for 3 doses	3	0
	☐ 30 mg/mL PEN	☐ Self-Administered Maintenance Dose: Inject 30 mg SubQ once every 8 weeks	1	_____

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

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REV1102223

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Nucala	☐ 100 mg Vial (Office Administered Only) ☐ 100 mg/mL Auto-Injector ☐ 100 mg/mL PFS	☐ Pediatric Severe Asthma (6-11 years of age): 40 mg SubQ to upper arm, thigh or abdomen once every 4 weeks (VIAL for Office Administration Only) ☐ Severe Asthma in Patients 12 years and older / CRSwNP in Patients 18 years and older: 100 mg SubQ to upper arm, thigh or abdomen once every 4 weeks ☐ Adult EGPA / HES in Patients 12 years and older: Inject 300 mg SubQ administered as 3 separate 100 mg injections to upper arm, thigh or abdomen once every 4 weeks	28-Day 28-Day 28-Day	_____ _____ _____
☐ Xolair To be administered: ☐ By a healthcare professional ☐ In the Home If administered in the home, has patient received at least 3 doses of Xolair, under HCP guidance, with no hypersensitivity reactions? ☐ Yes ☐ No				
☐ Asthma *(dose is dependent on weight and IgE levels, see package insert: 75 to 375 mg every 2 or 4 weeks)* ☐ CIU *(fixed dose, not dependent on weight or IgE levels: 150 or 300 mg every 4 weeks)* ☐ Nasal Polyposis *(75 to 600 mg every 2 or 4 weeks)*	☐ Prefilled Syringe *Pharmacy to dispense the least amount of 75 mg or 150 mg Syringes to complete total dose. PFS available in 75 mg and 150 mg strengths.* ☐ 150 mg Single Dose VIAL	☐ Every 4 weeks dosing: Administer: ☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 450 mg ☐ 600 mg ☐ Every 2 weeks dosing: Administer: ☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ 450 mg ☐ 525 mg ☐ 600 mg	28 Day	_____
☐ Epinephrine ☐ EpiPen	☐ 0.3 mg ☐ 0.15 mg	☐ Inject IM as needed for anaphylaxis ☐ Other: _____	_____	_____

_____ _____ _____ _____
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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REV.110223