ANKYLOSING SPONDYLITIS REFERRAL FORM (A-R)

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
Date of Diagnosis	Years with Disease	Prior Therapy ☐ No ☐ Yes (please list)	
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			
Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)		☐ Other Allergies (please list)	
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)			

ICD-10 Code

- ☐ M45.0 Ankylosing spondylitis of multiple sites in spine
- ☐ M45.1 Ankylosing spondylitis of occipito-atlanto-axial region
- ☐ M45.2 Ankylosing spondylitis of cervical region
- ☐ M45.3 Ankylosing spondylitis of cervicothoracic region
- ☐ M45.4 Ankylosing spondylitis of thoracic region
- ☐ M45.5 Ankylosing spondylitis of thoracolumbar region
- ☐ M45.6 Ankylosing spondylitis of lumbar region
- ☐ M45.7 Ankylosing spondylitis of lumbosacral region
- ☐ M45.8 Ankylosing spondylitis sacral and sacrococcygeal region
- ☐ M45.9 Ankylosing spondylitis of unspecified sites in spine

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
☐ Cimzia (certolizumab pegol)	☐ Starter Kit ☐ 200mg Prefilled Syringe ☐ 200mg Lyphollized Vial	Starter Dose: ☐ Inject 400mg SubQ once at weeks 0, 2 and 4	6	0
		Maintenance Dose: ☐ Inject 200mg SubQ once every 2 weeks ☐ Inject 400mg SubQ once every 4 weeks	4-week supply	
☐ Cosentyx (secukinumab)	☐ 150mg/mL Prefilled Syringe ☐ 150mg/mL Pen ☐ 150 mg/mL Sensoready Pen	Loading Dose: ☐ Inject 150mg SubQ once at weeks 0, 1, 2, 3 and 4	10	
		Maintenance Dose: ☐ Inject 150 mg SubQ once every 4 weeks ☐ Inject 300 mg (2x150 mg injections) SubQ once every 4 weeks	28 days	
☐ Enbrel (etanercept)	☐ 25mg/0.5mL Prefilled Syringe ☐ 25mg/0.5mL Single Dose Vial ☐ 50mg/mL Sureclick Autoinjector ☐ 50mg/mL Prefilled Syringe ☐ Mini 50mg/mL Cartridge	☐ Inject 50mg SubQ once weekly ☐ Inject 25mg SubQ twice weekly	4-week supply	
☐ Humira CF (adalimumab)	☐ 40mg/0.4mL Prefilled Syringe ☐ 40mg/0.4mL Pen	☐ Inject 40mg SubQ every other week	4-week supply	
☐ Remicade (infliximab)	☐ 100mg vial	Loading Dose: ☐ Infuse 5mg/kg IV at weeks 0, 2, and 6	QS	0
		Maintenance Dose: ☐ Infuse 5mg/kg IV every six weeks	6 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.*

REV010824

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PRESCRIBER INFORMATION

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Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

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Other/Concomitant Medications (please list)			
Allergies ☐ NKDA ☐ Drug Allergies (please list)		☐ Other Allergies (please list)	
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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Simponi (golimumab)	☐ 50mg/0.5mL Prefilled Syringe ☐ 50mg/0.5mL Smartject Pen	No Loading Dose Required: ☐ Inject 50mg SubQ once a month	1 month supply	
☐ Simponi Aria (golimumab)	☐ 50mg/4mL Vial	Loading Dose: ☐ Infuse 2 mg/kg IV at weeks 0 and 4	QS	0
		Maintenance Dose: ☐ Infuse 2 mg/kg IV every 8 weeks	8 weeks	
☐ Taltz (ixekizumab)	☐ 80mg/mL Prefilled Syringe ☐ 80mg/mL Autoinjector	Loading Dose: ☐ Inject 160 mg (2x80 mg injections) SubQ once on Day 1	2	0
		Maintenance Dose: ☐ Inject 80mg SubQ once every 4 weeks	4-week supply	
☐ Xeljanz	☐ 5mg tablet	☐ Take one tablet by mouth twice daily	60	
☐ Xeljanz XR	☐ 11mg tablet	☐ Take one tablet by mouth once daily	30	

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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