GASTROENTEROLOGY 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 ☐ New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date	ICD-10 Code:	Diagnosis:
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs): Date Obtained:
TB Test Results: Test Date:	Hepatitis B ruled out? ☐ Yes ☐ No	If no, has treatment been started? ☐ Yes ☐ No	
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	Does patient have a latex allergy? ☐ Yes ☐ No		
Therapies Tried and Failed (please list medications)			
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)			

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 *(Note: Cimzia vials should be prepared and administered by a health care professional)*	☐ 200 mg/mL PFS ☐ 200 mg Vial	Starter Dose: ☐ Inject 400 mg (2x200 mg injections) SubQ at Weeks 0, 2 and 4	6	0
		Maintenance Dose: ☐ Inject 400 mg (2x200 mg injections SubQ every 4 weeks	2x200 mg	
☐ Dupixent	☐ 300mg/2mL PFS ☐ 300mg/2mL PEN	Inject 300mg SubQ once weekly	4	
☐ Entyvio	☐ 300 mg Vial ☐ MD Office infusion ☐ Home Infusion	Starter Dose: ☐ Infuse 300 mg IV at Week 0, 2 and 6	3 Vials	0
		Maintenance Dose: ☐ Infuse 300 mg IV every 8 weeks	1 Vial	
☐ Humira CD/UC/HS Starter	80mg/0.8mL Pen			
☐ Humira CF	☐ 80 mg/0.8 mL Pen	Starter Dose: ☐ Inject 160 mg (2x80 mg injections) SubQ on Day 1, then 80 mg SubQ on Day 15 ☐ Inject 80 mg SubQ on Day 1 and Day 2, Then 80 mg SubQ on Day 15	3 Pens	0
	☐ 40 mg/0.4 mL Pen ☐ 40 mg/0.4 mL PFS	Maintenance Dose: ☐ Inject 40 mg SubQ on Day 29 & every other week thereafter	2	
☐ Remicade	☐ 100 mg Vial ☐ MD Office infusion ☐ Home Infusion Current Weight: _____kg	Starter Dose: ☐ 5 mg/kg ☐ 10 mg/kg Infuse _____ mg IV on Weeks 0, 2 & 6		0
		Maintenance Dose: ☐ 5 mg/kg ☐ 10 mg/kg Infuse _____ mg IV every _____ weeks		
☐ Rinvoq	☐ 45mg XR tablet	Induction dose: ☐ 45mg PO once daily for 8 weeks	56	0
	☐ 15mg XR tablet ☐ 30mgXR tablet	Maintenance dose: ☐ 15mg PO once daily ☐ 30mg PO 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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REV.010824

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GASTROENTEROLOGY REFERRAL FORM (S-X)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
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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 ☐ New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date	ICD-10 Code:	Diagnosis:
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs): Date Obtained:
TB Test Results: Test Date:	Hepatitis B ruled out? ☐ Yes ☐ No	If no, has treatment been started? ☐ Yes ☐ No	
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	Does patient have a latex allergy? ☐ Yes ☐ No		
Therapies Tried and Failed (please list medications)			
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)			

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Simponi	☐ 100 mg/mL SmartJect ☐ 100 mg/mL PFS	Starter Dose: Inject 200 mg (2x100 mg injections) SubQ at Week 0 and 100 mg SubQ at Week 2	3	0
		Maintenance Dose: Inject 100 mg SubQ every 4 weeks	1	
☐ Skyrizi	☐ 600mg/10mL SDV	Induction Dose: ☐ 600mg IV at week 0,4, and 8	3 Vials	
	☐ 180mg/1.2mL Cartridge with On-Body injector ☐ 360mg/2.4mL Cartridge with On-Body injector	☐ 180mg SubQ at week 12 and every 8 weeks thereafter ☐ 350mg SubQ at week 12 and every 8 weeks thereafter	1	
☐ Stelara *Note: Stelara is intended for use under the guidance and supervision of a physician with patients who will be closely monitored and have regular follow-up. Patients may self-inject with Stelara after physician approval and proper training.* *Administration: ☐ MD Office ☐ Self-Administration*	☐ 130 mg/26 mL Vial (weight-based) Current Weight: _____ kg	Induction Dose: Infuse: ☐ ≤55 kg: 260 mg IV as a single dose ☐ >55 kg to 85 kg: 390 mg IV as a single dose ☐ >85 kg: 520 mg IV as a single dose	2 Vials 3 Vials 4 Vials	0
	☐ 90 mg/1 mL PFS	Maintenance Dose: ☐ Inject 90 mg SubQ 8 weeks after first IV dose, then every 8 weeks thereafter	1	
☐ Xeljanz	☐ 10 mg Tablet ☐ 22 mg XR Tablet	Induction Dose: ☐ Take 10 mg by mouth twice daily x8 weeks ☐ Take 22 mg by mouth once daily x8 weeks	56 28	1
	☐ 5 mg Tablet ☐ 10 mg Tablet ☐ 11 mg XR Tablet ☐ 22 mg XR Tablet	Maintenance Dose: ☐ Take 5 mg by mouth twice daily ☐ Take 10 mg by mouth twice daily ☐ Take 11 mg by mouth once daily ☐ Tale 22 mg by mouth once daily	60 60 30 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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GASTROENTEROLOGY REFERRAL FORM (Y-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 #	

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TB Test Results: Test Date:	Hepatitis B ruled out? ☐ Yes ☐ No	If no, has treatment been started? ☐ Yes ☐ No	
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	Does patient have a latex allergy? ☐ Yes ☐ No		
Therapies Tried and Failed (please list medications)			
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)			

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Zeposia *Starter Kit Rx is only for on-label patients who will not receive a 37-day sample from their prescriber.*	Has patient already initiated Zeposia? ☐ No ☐ Yes (If yes, add start date: _____ and skip to maintenance section)	☐ Titration Dose – For New Patients: Days 1-4: 0.23 mg capsule by mouth once daily (4 caps) Days 5-7: 0.46 mg capsule by mouth once daily (3 caps) Day 8 and thereafter: 0.92 mg capsule by mouth once daily (30 caps) ☐ Titration Dose - For Patients Restarting: Days 1-4: 0.23 mg capsule by mouth once daily (4 caps) Days 5-7: 0.46 mg capsule by mouth once daily (3 caps) Starter Pack sent to: ☐ Prescriber address ☐ Patient Address (if assessments are completed)	1	0
	☐ 0.92 mg Capsule	Maintenance Dose: ☐ Take 0.92 mg capsule 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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