RHEUMATOLOGY INFUSION REFERRAL FORM (PAGE 1 OF 2)

PHONE 855.896.9254 | **FAX** 855.370.0086

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

** 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

Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided: — Patient Height (cm/in): Weight (kg/lbs): Date Obtained:

Therapies Tried and Failed (please list medications)

Other/Concomitant Medications (please list)

Allergies ☐ NKDA ☐ Drug Allergies (please list)

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

ICD-10 Code

☐ M32.8 Other forms of systemic lupus erythematosus
☐ M32.9 Other forms of systemic lupus erythematosus, unspecified
☐ M32.10 Systemic lupus erythematosus, organ or system involvement unspecified
☐ M32.19 Other organ or system involvement in systemic lupis erythematosus
☐ M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites w/o organ or systems involvement
☐ M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites
☐ M06.89 Other specified rheumatoid arthritis, multiple sites
☐ M06.9 Rheumatoid Arthritis
☐ Other _____

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	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Benlysta (belimumab)	☐ IV	☐ 10 mg/kg	Starting Dose ☐ 10 mg/kg IV at week 0, 2, 4 and then every ___ weeks Maintenance Dose ☐ 10 mg/kg IV every ___weeks	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Cimzia (certolizumab)	☐ IV	☐ 200 mg prefilled syringe ☐ 200 mg lyophilized powder vial	Starting Dose ☐ 400 mg (given as two 200 mg subcutaneous injections) at weeks 0,2 and 4 Maintenance Dose ☐ 200 mg subcutaneous injection every other week ☐ Other_____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Orencia (abatacept)	☐ IV	☐ 500 mg Orencia ☐ 750 mg Orencia ☐ 1000 mg Orencia	☐ Infuse over 30 minutes	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Remicade (infliximab)	☐ IV	Starting Dose ☐ 5 mg/kg ___mg IV at week 0,2,6 ☐ 3 mg/kg ___mg IV at week 0,2,6 ☐ Other _____ Maintenance Dose ☐ _____mg/kg IV every _____ weeks	☐ To be infused over a period NOT less than 2 hours	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Rituxan (rituximab)	☐ IV	☐ 1000 mg IV on day 0, day 14 and then repeat the course every ___weeks ☐ 375 mg/m2 IV every 4 weeks ☐ Other _____	☐ Infuse as directed	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ NPI # _____ 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.010824

RHEUMATOLOGY INFUSION REFERRAL FORM (PAGE 2 OF 2)

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AMBER SPECIALTY PHARMACY

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

Patient Last Name	Patient First Name	DOB

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	ROUTE	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Saphnelo (anifrolumab)	☐ IV	☐ 300 mg/2 mL Vial	☐ To be infused over 30 minutes every 4 weeks vi pump with 0.2 or 0.22 micron filter. Upon completion of the infusion, flush infusion set with 25 mL of 0.9 Sodium Chloride Injection, USP. Prior to initiating therapy, is patient positive for autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm)? ☐ Yes ☐ No Positive ANA or anti-dsDNA test? ☐ Yes (Date of Test: _____) ☐ No	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Simponi Aria (golimumab)	☐ IV	Starting dose ☐ 2 mg/kg ____mg IV at week 0, 4 and every 8 weeks ☐ Other_____ Maintenance Dose ☐ 2 mg/kg___mg IV every 8 weeks ☐ Other _____	☐ Infuse diluted solution over a period of 30 minutes	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____

☐ Vascular Access Method ☐ peripheral ☐ central ☐ other: _____

☐ Normal Saline ☐ D5W	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ Before and after infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Heparin 10 units/mL ☐ Heparin 100 units/mL	☐ IV	☐ 3 mL ☐ 5 mL ☐ _____	☐ After infusion ☐ _____	☐ 1 month ☐ 3 months ☐ _____	☐ 1 year ☐ _____
☐ Diphenhydramine	☐ PO ☐ IV ☐ IM	☐ 25 mg ☐ 50 mg ☐ _____	☐ After infusion ☐ PRN Allergic Reaction: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Famotidine	☐ IV	☐ 20 mg IVP ☐ 40 mg IVP	☐ Pre-Med: _____ ☐ _____		☐ 1 year ☐ _____
☐ Methylprednisolone	☐ IV	☐ 40 mg IVP ☐ 125 mg IVP ☐ _____	☐ Pre-Med: _____ ☐ _____		☐ 1 year ☐ _____
☐ Acetaminophen	☐ PO	☐ 325 mg ☐ 650 mg ☐ _____ ☐ 500 mg ☐ 1 gm	☐ Pre-Med: _____ ☐ _____	☐ With each infusion ☐ _____	☐ 1 year ☐ _____
☐ Epinephrine	☐ IM ☐ SQ	☐ Adult 1:1000, 0.3 mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3 mL (15-30kg/33-66lbs)	☐ PRN Anaphylaxis ☐ Repeating Dose: _____	☐ Once ☐ _____	☐ 1 year ☐ _____
☐ Other:	☐ _____				

Prescriber Signature _____ Date _____

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

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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