Amber PHARMACY DERMATOLOGY REFERRAL FORM A-H

Phone: (855) 896.9254 Fax: (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone		
SSN	Allergies	
Sex ❑ Male ❑ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax		

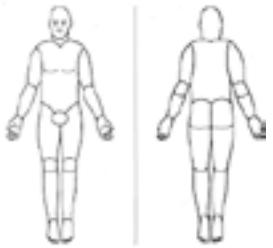
Diagnosis/Clinical Information

Diagnosis

❑ L40.0 Psoriasis vulgaris ❑ L40.8 Other psoriasis ❑ L73.2 Hidradenitis Suppurativa
❑ L40.9 Psoriasis, unspecified ❑ L40.5 Psoriatic arthritis ❑ Other: _____
Date of diagnosis or years with the disease: _____

Active TB is ruled out: ❑ Yes ❑ No Date of negative TB test: ____
Has HBV been ruled out or treatment been initiated? ❑ Yes ❑ No
NKDA ❑ Latex allergy ❑ Allergies: _____
_____
Concomitant medications: _____

Prior Therapy	Reason for Discontinuation	Start	End



❑ Hands ❑ Feet
❑ Groin ❑ Nails
❑ Other ❑ Scalp
BSA (% is required): ____ ❑ Face

Prescription Information

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QTY	REFILLS
Cimzia (Vials to be prepared and administered by healthcare professionals)	❑ 200mg/mL Prefilled Syringes ❑ 200mg/mL Vials	**Starter Dose:** ❑ Inject 400mg SQ at weeks 0, 2 and 4	6	0
		Maintenance Dose: ❑ Inject 400mg SQ every 4 weeks ❑ Inject 200mg SQ every 2 weeks	28 day	
Cosentyx	❑ 150mg/mL Sensoready Pen ❑ 150mg/mL Prefilled Syringe	**Starter Dose:** ❑ Inject 300mg SQ once weekly at weeks 0, 1, 2, 3 and 4	10	
		❑ Inject 150mg SQ once weekly at weeks 0, 1, 2, 3 and 4	5	0
		Maintenance: ❑ Inject 300mg SQ every 4 weeks ❑ Inject 150mg SQ every 4 weeks	28 day	
Enbrel	❑ 50mg/mL Sureclick Autoinjector ❑ 50mg/mL Prefilled Syringe ❑ 25mg/0.5mL Prefilled Syringe ❑ 25mg/mL vial	**Starter Dose:** (Psoriasis) ❑ Inject 50mg SQ twice a week (72-96 hrs apart) x 3 months ❑ Other:	28 day	2
		Maintenance Dose: ❑ Inject 50mg SQ once weekly ❑ Inject 25mg SQ twice weekly (72-96 hrs apart) ❑ Other:	28 day	
Humira	❑ 40mg/0.8mL Pens ❑ 40mg/0.8mL Prefilled Syringes	❑ **Psoriasis Starter Pack:** Inject 80mg SQ Day 1, then 40mg on Day 8, then 40mg every other week thereafter	4	0
		Hidradenitis Suppurativa: ❑ Inject 160mg SQ on Day 1, 80mg SQ on Day 15, then 40mg every week thereafter **-OR-** ❑ Inject 80mg SQ on Day 1 and Day 2, 80mg SQ on Day 15, then 40mg every week thereafter	6	0
		Maintenance Dose: ❑ Inject 40mg SQ every other week ❑ Inject 40mg SQ on day 29 and every week thereafter (Hidradenitis Suppurativa)	28 day	

Date needed: _____/_____/_____ Medication delivery to (choose one): ❑ Prescriber ❑ Home ❑ Other:

Injection training to be provided by: ❑ Prescriber's Office ❑ Hy-Vee Pharmacy Solutions ❑ Other:_____

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 substitution: _____

PRESCRIBER MUST MANUALLY SIGN THIS FORM - *(STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED)*

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) _____

DISPENSE AS WRITTEN/Do Not Substitute (date) _____

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.