Amber PHARMACY DERMATOLOGY REFERRAL FORM I-Z

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

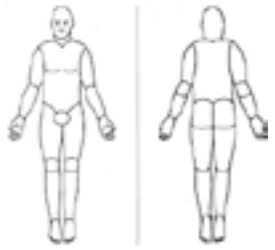
Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Email		

Diagnosis/Clinical Information

Diagnosis ❑ L40.0 Psoriasis vulgaris ❑ L40.8 Other psoriasis ❑ Other: _____
❑ L40.9 Psoriasis, unspecified ❑ L40.5 Psoriatic arthritis ❑ L73.2 Hidradenitis Suppurativa
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 ❑ Other:_____
Concomitant medications: _____
Allergies: _____

Prior Therapy	Reason for Discontinuation	Start	End



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

Prescription Information

DRUG	DOSAGE/STRENGTH	SIG	QTY	REFILLS
Otezla	❑ **Titration Dose:** ❑ Titration Starter Pack	**Titration Dose:** ❑ Take as directed per package instructions.	1 pack (28 day)	0
	❑ **Bridge Dose:** ❑ Bridge Dose	**Bridge Dose:** ❑ Take 30mg twice daily (Bridge) ❑ Take 30mg once daily (Bridge)	28 day 28 day	
	❑ **Maintenance Dose:** ❑ 30mg Tablet	**Maintenance Dose:** ❑ Take 30mg twice daily ❑ Take 30mg once daily	30 days	
Remicade Current Weight _____kg	❑ **Starter Dose:** ❑ 100mg Vial	**Starter Dose:** ❑ 5mg/kg (_____mg) IV at week 0, week 2 and week 6	QS	0
	❑ **Maintenance Dose:** ❑ 100mg Vial	**Maintenance Dose:** ❑ 5mg/kg (_____mg) IV every 8 weeks	56 day	
Simponi (for Psoriatic Arthritis only)	❑ **Starter Dose:** ❑ 50mg/0.5mL Autoinjector ❑ 50mg/0.5mL Prefilled Syringe	**Starter Dose:** ❑ Inject 50mg SQ once a month	30 day	2
Stelara Current Weight _____kg	❑ **Patients < 100kg:** ❑ 45mg/0.5mL Prefilled Syringe ❑ 45mg/0.5mL Prefilled Syringe	**Patients <100kg:** ❑ **INITIAL DOSE:** Inject 45mg SQ initially (week 0) and 4 weeks later ❑ **MAINTENANCE DOSE:** Inject 45mg SQ every 12 weeks starting on week 4	QS 84 day	
	❑ **Patients > 100kg:** ❑ 90mg/1mL Prefilled Syringe ❑ 90mg/1mL Prefilled Syringe	**Patients >100kg:** ❑ **INITIAL DOSE:** Inject 90mg SQ initially (week 0) and 4 weeks later ❑ **MAINTENANCE DOSE:** Inject 90mg SQ every 12 weeks	28 day 84 day	
Taltz	❑ **Starter Dose:** ❑ 80mg/1mL Autoinjector ❑ 80mg/1mL Prefilled Syringe	**Starter Dose:** ❑ Inject 160mg SQ at week 0, then 80mg SQ at weeks 2, 4, 6, 8,10 and 12	QS	0
	❑ **Maintenance Dose:** ❑ 80mg/1mL Autoinjector ❑ 80mg/1mL Prefilled Syringe	**Maintenance:** ❑ Inject 80mg SQ every 4 weeks	28 day	

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

Injection training to be provided by: ❑ Prescriber's Office ❑ Amber Pharmacy ❑ 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.