DERMATOLOGY REFERRAL FORM P-Z

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies	Latex Allergy ☐ Yes ☐ No	
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	Email	

Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Diagnosis: ☐ L20._____ Atopic Dermatitis ☐ L40.0 Psoriasis vulgaris/Plaque psoriasis/Nummular psoriasis ☐ L40.8 Other psoriasis
☐ L40.9 Psoriasis, unspecified ☐ L40.5____ Psoriatic arthritis ☐ L73.2 Hidradenitis Suppurativa ☐ Other: _____

Date of diagnosis or years with the disease: _____

Active TB is ruled out: ☐ Yes ☐ No Date of negative TB test: _____/_____/_____

Concomitant medications: _____

Previous treatment regimens with dates and reason for discontinuation: _____

_____

Prescription Information

MEDICATION		DOSE/STRENGTH/DIRECTIONS FOR USE	QTY	REFILLS
☐ **Remicade®** **Weight _____kg** Biosimilars: ☐ **Inflectra®** ☐ **Renflexis®**	Vial	☐ Starter dose: 5mg/kg (_____mg) IV at weeks 0, 2 and 6	☐ QS	0
		☐ Maintenance dose: 5mg/kg(_____mg) IV every 8 weeks	☐ 56 day	_____
☐ **Siliq®**	PFS	☐ Starter dose: Inject 210mg SC on weeks 0, 1 and 2, inject 210mg SC every 2 weeks thereafter	☐ 4 x 210mg/1.5ml	0
		☐ Maintenance dose: Inject 210mg SC every 2 weeks	☐ 2 x 210mg/1.5ml	_____
☐ **Simponi®**	☐ SmartJect Autoinjector ☐ PFS	☐ Inject 50mg SC once a month	☐ 1 x 50mg/0.5ml	_____
☐ **Stelara®** **Weight _____kg**	PFS	☐ Starter dose: Inject 45mg SC on Day 1 (≤100 kg) ☐ Starter dose: Inject 90mg SC on Day 1 (>100 kg)	☐ 1 x 45mg/0.5ml ☐ 1 x 90mg/ml	0
		☐ Maintenance dose: Inject 45mg SC on Day 29 and every 12 weeks thereafter (≤100 kg) ☐ Maintenance dose: Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100 kg)	☐ 1 x 45mg/0.5ml ☐ 1 x 90mg/ml	_____
☐ **Taltz®**	☐ Autoinjector ☐ PFS	☐ Starter dose: Inject 160mg (2 x 80mg) SC at week 0, then inject 80mg SC at week 2	☐ 3 x 80mg/ml	0
	☐ Autoinjector ☐ PFS	☐ Starter dose: Inject 80mg SC at week 4 and every 2 weeks thereafter through week 10	☐ 4 x 80mg/ml	0
	☐ Autoinjector ☐ PFS	☐ Maintenance dose: Inject 80mg SC at week 12 and every 4 weeks thereafter	☐ 1 x 80mg/ml	_____
☐ **Tremfya®**	PFS	☐ Starter dose: Inject 100mg SC at week 0, then 100mg at week 4 and every 8 weeks thereafter	☐ 2 x 100mg/ml	0
		☐ Maintenance dose: Inject 100mg SC every 8 weeks	☐ 1 x 100mg/ml	_____

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 - 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.