

DERMATOLOGY REFERRAL FORM

P-Z

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



Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Prescriber NPI			
Latex Allergy Yes No						Nurse/Key Contact		Phone/Pager	
Sex	Male	Female	Weight (kg)		Height (ft,in)		Fax		
Insurance Plan			Plan ID #			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	
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)		1 x 45mg/0.5ml	0
		Starter dose: Inject 90mg SC on Day 1 (>100 kg)		1 x 90mg/ml	_____
		Maintenance dose: Inject 45mg SC on Day 29 and every 12 weeks thereafter (≤100 kg)		1 x 45mg/0.5ml	_____
Maintenance dose: Inject 90mg SC on Day 29 and every 12 weeks thereafter (>100 kg)		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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.