INFUSION THERAPY

Phone (888)370.1724 Fax (855)370.0086

Amber PHARMACY

Patient Information

PATIENT DEMOGRAPHIC IS ATTACHED

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Temporary Address or Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Date of Birth	Gender (M/F)	Weight	Height	Diagnosis

Special Instructions (allergies, language preference, etc.)

Primary Caregiver/Phone	Emergency Contact/Phone

Healthcare Provider Information: **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Physician DEA#	Physician State License #

Nurse/Key Contact	Phone or Pager Number	Email

Insurance Information

Primary Insurance	Phone	Name/SSN of Insured	ID Number	Group Number

Secondary Insurance	Phone	Name/SSN of Insured	ID Number	Group Number

Other Insurance/Prescription Drug Vendor (Rx Bin #)

Additional Information

Today's Date	Date Meds Needed	May we contact this patient? ❑ Yes ❑ No	Additional Information/Instructions

Medication	Dose/Strength	Sig	Quantity	Refills
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

INSURANCE CARD FRONT AND BACK PATIENT DEMOGRAPHIC ATTACHED

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)*

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:

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) _____

DISPENSE AS WRITTEN/Do Not Substitute (date) _____