Amber PHARMACY

# Rheumatology Referral Form

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

## Patient Information

| Last Name | First Name | Home Phone | Work/Mobile Phone |
|---|---|---|---|
| | | | |

| Home Address | City | State | ZIP |
|---|---|---|---|
| | | | |

| Shipping Address (if different from above) | City | State | ZIP |
|---|---|---|---|
| | | | |

| Social Security Number | Gender (M/F) | Weight | Date of Birth | Allergies |
|---|---|---|---|---|
| | | | | |

| Emergency Contact | Phone | Primary Caregiver | Phone |
|---|---|---|---|
| | | | |

## Healthcare Provider Information: **Indicates Required Field*

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

| **Address*** | **City*** | **State*** | **ZIP*** |
|---|---|---|---|
| | | | |

| **Physician NPI#*** | Physician UPIN# | Physician DEA# | Physician State License # |
|---|---|---|---|
| | | | |

| Nurse/Key Contact | Phone or Pager Number | Email |
|---|---|---|
| | | |

## Insurance Information: *PLEASE FAX A COPY OF INSURANCE CARD (FRONT AND BACK)*

Diagnosis: ❑ 714.0 Rheumatoid Arthritis ❑ 696.0 Psoriatic Arthritis ❑ 720.0 Ankylosing Spondylitis
❑ Other: Date of Diagnosis or Years with Disease:

Other clinical information:

**Hepatitis B test result:** ❑ Positive ❑ Negative **TB test result:** ❑ Positive ❑ Negative **Does patient have a latex allergy?** ❑ Yes ❑ No **Is patient also taking Methotrexate?** ❑ Yes ❑ No

Current/Prior Therapies: _____

## Delivery Information

| Today's Date | Delivery Date | Deliver to: ❑ Home ❑ Physician | Amber Pharmacy to initiate arrangement of injection training to take place at patient's home ❑ Yes ❑ No | Special Instructions |
|---|---|---|---|---|
| | | | | |

| Medication | Dose/Strength | Sig | Qty. | Refills |
|---|---|---|---|---|
| ❑ Actemra® | ❑ 162mg (0.9ml) Prefilled syringe | ❑ 162mg SC every OTHER week<br>❑ 162mg SC ONCE a week<br>❑ Alternate Dosing: _____ | 2<br>4<br>____ | ____ |
| ❑ Cimzia® | **Starter Dose:**<br>❑ 200mg/ml Prefilled syringe<br>❑ 200mg Lyophilized powder vial | Initial dose of 400mg SC at weeks 0, 2, and 4 | 1 kit<br>3 kits | 0 |
| | **Maintenance Dose:**<br>❑ 200mg/ml Prefilled syringe<br>❑ 200mg Lyophilized powder vial | ❑ 400mg SC every 4 weeks<br>❑ 200mg SC every 2 weeks | 4-week supply | ____ |
| ❑ Enbrel® | ❑ 50mg/ml Sureclick™ Autoinjector<br>❑ 50mg/ml Prefilled syringes<br>❑ 25mg Vial (inj supplies included)<br>❑ 25mg /0.5ml Prefilled syringe | ❑ Inject 50mg SQ ONCE a week<br>❑ Inject 25mg SQ TWICE a week<br>❑ Alternate Dosing: _____ | 4-week supply | ____ |
| ❑ Humira® | ❑ 40mg/0.8ml Pen<br>❑ 40mg/0.8ml Prefilled syringe | ❑ Inject 40mg SC every OTHER week<br>❑ Inject 40mg SC ONCE a week<br>❑ Alternate Dosing: _____ | 4-week supply | |
| ❑ Orencia® | ❑ 250mg Vial (IV use only) | ❑ Loading Dose: 10mg/kg IV x 1 dose, then 125mg SC weekly, start within 24 hours of IV dose | 1 dose | 0 |
| | ❑ 125mg/ml Prefilled syringe | ❑ 125mg SC ONCE a week | 4-week supply | ____ |
| ❑ Simponi® | ❑ 50mg/0.5ml Autoinjector<br>❑ 50mg/0.5ml Prefilled syringe | ❑ Inject 1 single-use Autoinjector SC ONCE monthly<br>❑ Inject 1 single-use Prefilled syringe SC ONCE monthly | 1 (one) | ____ |
| ❑ Xeljanz® | ❑ 5mg tablet | ❑ 5mg PO BID<br>❑ Alternate Dosing: _____ | ____ | ____ |
| ❑ | | | | |

*****When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards*****

**Physician Signature:**_____ ❑ **DAW** (Dispense as Written) **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.