DERMATOLOGY REFERRAL FORM (A-C)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

Please include a copy of the front and back of insurance card

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date			
Sample/Starter Product Provided? ☐ Yes ☐ No If yes, Provide Qty:	Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Test Results	Test Date		
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Latex ☐ Drug Allergies (please list) ☐ Other (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted
ICD-10 Codes ☐ L20.9 Atopic dermatitis, unspecified ☐ L40.0 Psoriasis vulgaris ☐ L40.50 Arthropathic psoriasis, unspecified ☐ L73.2 Hidradenitis, suppurativa ☐ L28.1 Prurigo nodularis ☐ Other _____ ☐ Date of Diagnosis _____				

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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 substitutions. This form is not a valid prescription form for writing controlled medications.

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Bimzelx	☐ 160mg/ml AutoInjector ☐ 160mg/ml Syringe	Initial Dose: ☐ 320mg (2x160mg) SC once every 4 weeks for 16 weeks Maintenance Dose: ☐ 320mg (2x160mg) SC once every 8 weeks	2	
☐ Cibinqo	☐ 50 mg Tablet ☐ 100 mg Tablet ☐ 200 mg Tablet	☐ Take one tablet by mouth once daily, with or without food, at the same time each day.	30	
☐ Cimzia®	☐ 200mg x2 PFS ☐ 200mg x2 Vials	☐ (PsO) Inject 400mg (as two-200mg injections) subcutaneously every other week ☐ (PsO) Alternate load (pt ≤90kg): Inject 400mg (as two-200mg injections) at weeks 0, 2, and 4 ☐ (PsO) Alternate maintenance (pt ≤90kg): Inject 200mg subcutaneously every other week ☐ (PsA) Starter Kit: Inject 400mg (as two-200mg injections) subcutaneously at weeks 0, 2, and 4 ☐ (PsA) Maintenance: Inject 400mg subcutaneously every 4 weeks ☐ (PsA) Maintenance: Inject 200mg subcutaneously every 2 weeks		
☐ Cosentyx®	300mg (2x150mg) ☐ Pen ☐ PFS 150mg ☐ Pen ☐ PFS	☐ Load: Inject 300mg subcutaneously on week 0, 1, 2, 3 ☐ Maintenance: Inject 300mg subcutaneously on week 4, then every 4 weeks thereafter ☐ Load: Inject 150mg subcutaneously on week 0, 1, 2, 3 ☐ Maintenance: Inject 150mg subcutaneously on week 4, then every 4 weeks thereafter		

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

REV.072624

DERMATOLOGY REFERRAL FORM (D-I)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date			
Sample/Starter Product Provided? ☐ Yes ☐ No If yes, Provide Qty:	Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Test Results	Test Date		
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Latex ☐ Drug Allergies (please list) ☐ Other (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted
ICD-10 Codes ☐ L20.9 Atopic dermatitis, unspecified ☐ L40.0 Psoriasis vulgaris ☐ L40.50 Arthropathic psoriasis, unspecified ☐ L73.2 Hidradenitis, suppurativa ☐ L28.1 Prurigo nodularis ☐ Other _____ ☐ Date of Diagnosis _____				

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Dupixent®	300mg ☐ Pen ☐ PFS w/Shield	☐ Load: Inject 600mg (as two-300mg injections in different sites) on day 1, then inject 300mg every other week starting on day 15 ☐ Maintenance: Inject 300mg subcutaneously every other week		
	200mg ☐ Pen ☐ PFS w/Shield	☐ Load: Inject 400mg (as two-200mg injections in different sites) on day 1, then inject 200mg every other week starting on day 15 ☐ Maintenance: Inject 200mg subcutaneously every other week		
☐ Enbrel®	☐ 50 mg SureClick Auto-Injector ☐ 50 mg PFS ☐ 50 mg Mini Cartridge ☐ 25 mg PFS ☐ 25 mg SDV	☐ Load: Inject 50mg subcutaneously twice a week, 72-96 hours apart x3 months ☐ Maintenance: Inject 50mg subcutaneously once a week ☐ Other: _____ Pediatric Weight: _____ Date Taken: _____		
☐ Eucrisa	2% Ointment ☐ 60gm ☐ 100gm	☐ Apply a thin layer to affected area(s) twice daily		
☐ Humira CF (Plaque Psoriasis)	☐ Starter Pack (CF): 80 mg/0.8 mL, 40 mg/0.4 mL PENS	Initial Dose: ☐ Inject 80 mg SC on day 1, followed by 40 mg SC on Day 8 & Day 22	1 Starter Pack	
	☐ 40 mg/0.4 mL PFS (CF) ☐ 40 mg/0.4 mL PEN (CF)	Maintenance Dose: ☐ Inject 40 mg SC every other week. ☐ Other: _____		
☐ Humira CF (Hidradenitis Suppurativa)	☐ Starter Pack (CF): 80 mg/0.8 mL PENS	Initial Dose: ☐ Inject 160mg (2 x 80 mg) SC on Day 1, then 80mg SC two weeks later (on Day 15). ☐ Inject 80 mg SC on Day 1, 80 mg SC on Day 2, then 80 mg SC two weeks later (on Day 15).	1 Starter Pack	
	☐ 40 mg/0.4 mL (CF) PEN ☐ 40 mg/0.4 mL (CF) PFS ☐ 80 mg/0.8 mL (CF) PEN	Maintenance Dose: ☐ Inject 40 mg SC on Day 29 and every week thereafter. ☐ Inject 80 mg SC on Day 29 and every other week thereafter.		
☐ Humira CF (Psoriatic Arthritis)	☐ 40 mg/0.4 mL (CF) PEN ☐ 40 mg/0.4 mL (CF) PFS	Maintenance Dose: ☐ Inject 40mg SC every other week. Other: _____		
☐ Ilumya	☐ 100mg/ml PFS	☐ Inject 100mg at Weeks 0,4, and every 12 weeks thereafter		

_____ _____ _____ _____

Prescriber Signature | Date | Supervising Physician Signature (where required by state law) | Date

_____ _____ _____

DAW (Dispense as Written) | Date | Brand Necessary (must handwrite)

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REV.072624

DERMATOLOGY REFERRAL FORM (J-S)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date			
Sample/Starter Product Provided? ☐ Yes ☐ No If yes, Provide Qty:	Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Test Results	Test Date		
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Latex ☐ Drug Allergies (please list) ☐ Other (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted
ICD-10 Codes ☐ L20.9 Atopic dermatitis, unspecified ☐ L40.0 Psoriasis vulgaris ☐ L40.50 Arthropathic psoriasis, unspecified ☐ L73.2 Hidradenitis, suppurativa ☐ L28.1 Prurigo nodularis ☐ Other _____ ☐ Date of Diagnosis _____				

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Opzelura	☐ 1.5% Cream	Apply a thin layer twice daily to affected areas; application area should not exceed 20% BSA. Do not use more than 60 grams (1 tube) per week. Discontinue when signs/symptoms resolve.		
☐ Orencia	☐ 250mg Vial ☐ 125mg PFS ☐ 125mg Clickjet Pen	Inject 125mg Subcutaneously once weekly		
☐ Otezla®	☐ Starter Pack ☐ 30mg Tablet	☐ Take 1 tablet on day 1 then twice daily as directed ☐ Take 1 tablet by mouth twice daily		
☐ Remicade	☐ Vial (weight based)	☐ Starter dose: 5mg/kg (_____ mg) IV at weeks 0,2 and 6 ☐ Maintenance Dose: 5mg/kg (_____ mg) IV every 8 weeks		
☐ Rinvoq	☐ 15 mg ER Tablet	☐ Take one tablet by mouth once daily	30	
	☐ 30 mg ER Tablet	☐ Take one tablet by mouth once daily *(For patients 12-65 yo with inadequate response to 15 mg QD & who are not taking strong CYP3A4 inhibitors and do not have severe renal impairment)*	30	
☐ Siliq®	☐ 210mg PFS	☐ Load: Inject 210mg subcutaneously on weeks 0, 1, and 2, then every 2 weeks thereafter ☐ Maintenance: Inject 210mg subcutaneously every 2 weeks		
☐ Simponi®	50mg ☐ SmartJect® ☐ PFS	Inject 50mg subcutaneously once a month as directed		
☐ Skyrizi™	150mg ☐ Pen ☐ PFS	☐ Starter: Inject 150mg subcutaneously on week 0 ☐ Maintenance: Inject 150mg subcutaneously on week 4, then every 12 weeks thereafter		
☐ Stelara®	☐ 45mg PFS (Weight ≤100kg) ☐ 90mg PFS (Weight >100kg) ☐ 45mg Vial (For Adol: <60kg)	☐ Starter: Inject 1 syringe subcutaneously on week 0 ☐ Maintenance: Inject 1 syringe subcutaneously on week 4, and then every 12 weeks thereafter ☐ Starter: Inject _____ mg (0.75mg/kg) subcutaneously on week 0 ☐ Maintenance: Inject _____ mg (0.75mg/kg) subcutaneously on week 4, then every 12 weeks thereafter		

Prescriber Signature _____ Date _____

Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____

Brand Necessary (must handwrite) _____

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REV.072624

DERMATOLOGY REFERRAL FORM (T-Z)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		
Referral Contact Email	Office Phone	Office Fax		
Practice / Facility Name	Prescriber Name / Specialty			
Address	City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #	

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes

Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date			
Sample/Starter Product Provided? ☐ Yes ☐ No If yes, Provide Qty:	Date Sample Provided			
If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No	TB Test Results	Test Date		
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Latex ☐ Drug Allergies (please list) ☐ Other (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained	% BSA impacted	BSA Areas impacted
ICD-10 Codes ☐ L20.9 Atopic dermatitis, unspecified ☐ L40.0 Psoriasis vulgaris ☐ L40.50 Arthropathic psoriasis, unspecified ☐ L73.2 Hidradenitis, suppurativa ☐ L28.1 Prurigo nodularis ☐ Other _____ ☐ Date of Diagnosis _____				

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Taltz®	80mg ☐ Autoinjector ☐ PFS	☐ Load (Plaque psoriasis): Inject 160mg (as two-80mg injections) subcutaneously on week 0, then 80mg on week 2, then Inject 80mg subcutaneously every 2 weeks (weeks 4-10), then Inject 80mg subcutaneously at week 12 ☐ Load (Psoriatic arthritis): Inject 160mg (as two-80mg injections) subcutaneously on week 0 ☐ Maintenance: Inject 80mg subcutaneously every 4 weeks		
☐ Tremfya®	100mg ☐ One-Press Injector ☐ PFS	☐ Starter: Inject 100mg subcutaneously on week 0 ☐ Maintenance: Inject 100mg subcutaneously on week 4, then every 8 weeks thereafter		
☐ Xeljanz	☐ 5mg Tablet ☐ 11mg XR Tablet	☐ Take one 5mg tablet PO twice daily ☐ Take one 11mg tablet PO once daily		
☐ Zoryve 0.3% Cream (3 mg roflumilast/gm)	☐ 60 gm Tube	☐ Apply to affected area(s) once daily ☐ Other: _____ Involved area(s) of skin: _____		
☐ Other _____				
☐ Other _____				
☐ Other _____				

_____ Prescriber Signature

_____ Date

_____ Supervising Physician Signature (where required by state law)

_____ Date

_____ DAW (Dispense as Written)

_____ Date

_____ Brand Necessary (must handwrite)

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

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