# CARDIOLOGY REFERRAL FORM

**Phone 855.896.9254 Fax 877.645.7514**
10004 S. 152nd St, Suite A, Omaha NE 68138

AMBER™ SPECIALTY PHARMACY

## Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

| | | |
|---|---|---|
| Last Name | First Name | DOB |
| Address | | |
| City | State | ZIP |
| Phone | Email | |
| SSN | Allergies | |
| 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 | |

## Clinical Assessment

*Please FAX recent clinical notes, labs and tests with the prescription to expedite the Prior Authorization process*

**Diagnosis (ICD-10)** ❑ **E78.01** (Familial Hypercholesterolemia) **Type of Familial Hypercholesterolemia:** ❑ **HeFH** (Heterozygous) ❑ **HoFH** (Homozygous)
❑ **E78.0** (Pure Hypercholesterolemia) ❑ **E78.2** (Mixed Hyperlipidemia) ❑ **E78.4** (Other Hyperlipidemia) ❑ **E78.5** (Unspecified Hyperlipidemia)

*For clinical ASCVD patients, please select the appropriate ICD code for hypercholesterolemia AND include the specific ASCVD diagnosis code.*

**ASCVD-Specific Code (ICD-10):** _____

**History of ASCVD Event:** ☒ **None** ☐ **Yes (select all that apply):** ☐ Unstable Angina ☐ Angina Pectoris ☐ Acute Myocardial Infarction
☐ Subsequent Myocardial Infarction ☐ Chronic Ischemic Heart Disease ☐ Cerebral Infarction ☐ Other Cerebrovascular Diseases
☐ Occlusion and stenosis of Cerebral Arteries, Intracranial ☐Other: _____

### Previous Lipid-Lowering Treatments: ❑ None ❑ Yes (Check all that apply)

| | Strength/Freq | Dates of Therapy |
|---|---|---|
| ❑ atorvastatin | _____mg/ _____ | mm/yy _____ to _____ |
| ❑ ezetimibe | _____mg/ _____ | mm/yy _____ to _____ |
| ❑ pravastatin | _____mg/ _____ | mm/yy _____ to _____ |
| ❑ rosuvastatin | _____mg/ _____ | mm/yy _____ to _____ |
| ❑ simvastatin | _____mg/ _____ | mm/yy _____ to _____ |
| ❑ Other: _____ | _____mg/ _____ | mm/yy _____ to _____ |
| ❑ Other: _____ | _____mg/ _____ | mm/yy _____ to _____ |

### Other Lipid-Lowering Agents to be Used Concurrently with PCSK9 Treatment:

❑ None ❑ Yes (Please indicate below):

_____
_____
_____

**Is the patient statin intolerant?** ❑ Yes ❑ No **If Yes, describe intolerance:** _____

**Any other contraindications to non-PCSK9 therapy for hypercholesterolemia?** _____

**Lab Values:** ❑ LDL-C _____ mg/dL Date: _____ **Drug Allergies:** _____

❑ Sharps container and alcohol pads to be provided as needed ❑ Injection training needed

## Additional Information/Special Instructions

| Medication | Dose/Strength | Directions for Use | Quantity | Refills |
|---|---|---|---|---|
| ❑ **Praluent®** ❑ Pre-Filled **Pen** | ❑ 75 mg/ml 2-Pack<br>❑ 150 mg/ml 2-Pack | ❑ Inject 75 mg SQ every 2 weeks<br>❑ Inject 150 mg SQ every 2 weeks | 28 days | |
| ❑ **Repatha™** Pre-Filled **Syringe** | ❑ 140 mg/ml 1-Pack (Syringe) | ❑ Inject 140 mg SQ every 2 weeks (2 Syringes)<br>❑ Inject 420 mg SQ once monthly (3 Syringes) | 28 days<br>One month | |
| ❑ **Repatha™ SureClick® Autoinjector** | ❑ 140 mg/ml 2-Pack (Pen) | ❑ Inject 140 mg SQ every 2 weeks | 28 days | |
| ❑ **Repatha™ Pushtronex™ System** | ❑ 420mg/3.5ml single-use Pushtronex™ System | ❑ Inject 420mg once monthly (over 9 minutes by using the single-use on-body infusor with pre-filled cartridge) | One month | |

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.