

CARDIOLOGY REFERRAL FORM

Phone 855.896.9254 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	Email		Prescriber Name					
SSN	Allergies		Prescriber NPI					
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (kg)	Height (ft,in)	Nurse/Key Contact		Phone/Pager			
Insurance Plan	Plan ID #		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:	Other Lipid-Lowering Agents to be Used Concurrently with PCSK9 Treatment:																								
<input type="checkbox"/> None <input type="checkbox"/> Yes (Check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Yes (Please indicate below):																								
<table border="0"> <thead> <tr> <th></th> <th>Strength/Freq</th> <th>Dates of Therapy</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> atorvastatin</td> <td>_____ mg/ _____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> ezetimibe</td> <td>_____ mg/ _____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> pravastatin</td> <td>_____ mg/ _____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> rosuvastatin</td> <td>_____ mg/ _____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> simvastatin</td> <td>_____ mg/ _____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td>_____ mg/ _____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td>_____ mg/ _____</td> <td>mm/yy _____ to _____</td> </tr> </tbody> </table>		Strength/Freq	Dates of Therapy	<input type="checkbox"/> atorvastatin	_____ mg/ _____	mm/yy _____ to _____	<input type="checkbox"/> ezetimibe	_____ mg/ _____	mm/yy _____ to _____	<input type="checkbox"/> pravastatin	_____ mg/ _____	mm/yy _____ to _____	<input type="checkbox"/> rosuvastatin	_____ mg/ _____	mm/yy _____ to _____	<input type="checkbox"/> simvastatin	_____ mg/ _____	mm/yy _____ to _____	<input type="checkbox"/> Other: _____	_____ mg/ _____	mm/yy _____ to _____	<input type="checkbox"/> Other: _____	_____ mg/ _____	mm/yy _____ to _____	_____ _____ _____
	Strength/Freq	Dates of Therapy																							
<input type="checkbox"/> atorvastatin	_____ mg/ _____	mm/yy _____ to _____																							
<input type="checkbox"/> ezetimibe	_____ mg/ _____	mm/yy _____ to _____																							
<input type="checkbox"/> pravastatin	_____ mg/ _____	mm/yy _____ to _____																							
<input type="checkbox"/> rosuvastatin	_____ mg/ _____	mm/yy _____ to _____																							
<input type="checkbox"/> simvastatin	_____ mg/ _____	mm/yy _____ to _____																							
<input type="checkbox"/> Other: _____	_____ mg/ _____	mm/yy _____ to _____																							
<input type="checkbox"/> Other: _____	_____ mg/ _____	mm/yy _____ to _____																							

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
<input type="checkbox"/> Praluent® <input type="checkbox"/> Pre-Filled Pen	<input type="checkbox"/> 75 mg/ml 2-Pack <input type="checkbox"/> 150 mg/ml 2-Pack	<input type="checkbox"/> Inject 75 mg SQ every 2 weeks <input type="checkbox"/> Inject 150 mg SQ every 2 weeks	28 days	
<input type="checkbox"/> Repatha™ Pre-Filled Syringe	<input type="checkbox"/> 140 mg/ml 1-Pack (Syringe)	<input type="checkbox"/> Inject 140 mg SQ every 2 weeks (2 Syringes) <input type="checkbox"/> Inject 420 mg SQ once monthly (3 Syringes)	28 days One month	
<input type="checkbox"/> Repatha™ SureClick® Autoinjector	<input type="checkbox"/> 140 mg/ml 2-Pack (Pen)	<input type="checkbox"/> Inject 140 mg SQ every 2 weeks	28 days	
<input type="checkbox"/> Repatha™ Pushtronex™ System	<input type="checkbox"/> 420mg/3.5ml single-use Pushtronex™ System	<input type="checkbox"/> 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.

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.