CARDIOLOGY
REFERRAL FORM

PATIENT INFORMATION

Last Name	First Name	DOB
Gender	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)		
Caregiver/Alt Contact Email	Caregiver/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	
Address	
City	State / ZIP
Prescriber Name / Specialty	
Prescriber State License #	DEA #
NPI #	Medicaid UPIN #

INSURANCE INFORMATION

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

CLINICAL INFORMATION

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	Allergies ☐ NKDA ☐ Drug Allergies (please list)	

Past Medical History Includes
☐ Myocardial Infarction ☐ Peripheral Arterial Disease ☐ Stable or Unstable Angina
☐ Acute Liver Disease ☐ Rhabdomyolisis ☐ Coronary/Arterial Revascularization
☐ De-Compensated Liver Disease ☐ Other ___________________________

Lab Values: Current LDL-C	Date

Previous Lipid-Lowering Treatments (please check all that apply)

	Dose/Frequency	Start Date	Stop Date
☐ Atorvastatin	____________	____________	____________
☐ Pravastatin	____________	____________	____________
☐ Rosuvastatin	____________	____________	____________
☐ Simvastatin	____________	____________	____________
☐ Ezetimibe	____________	____________	____________
☐ Other ____________	____________	____________	____________

Is the patient statin intolerant? ☐ Yes ☐ No	If yes, Describe Intolerance:

Other Lipid-Lowering Agents to be Used Concurrently w/ PCSK9 Treatment (please list)		
Any other contraindications to non-PCSK9 therapy for hypercholesterolemia?		
Patient Height (cm/in)	Patient Weight (kg/lbs)	Date Obtained
Other/Concomitant Medications		
Ship to Address	☐ Home ☐ Prescriber's Office ☐ Other (please list)	

ICD-10 Codes

(please select at least one primary and one secondary code)

Primary
- ☐ E78.00 Pure Hypercholesterolemia
- ☐ E78.01 Familial Hypercholesterolemia
  - ☐ Heterozygous (HeFH)
  - ☐ Homozygous (HoFH)
- ☐ E78.2 Mixed Hyperlipidemia
- ☐ E78.4 Other Hyperlipidemia
- ☐ E78.5 Unspecified Hyperlipidemia

Secondary
- ☐ G46.___ Transient Cerebral Ischemia Attack
- ☐ I21.____ ☐ I22.____ ☐ I23.____ Ischemic Heart Disease
- ☐ I25.____ Chronic Ischemic Heart Disease
- ☐ I63.____ ☐ I65____ ☐ I66.____ ☐ I67.___
- ☐ I70.____ Atherosclerosis
- ☐ I73.____ Other Peripheral Vascular Diseases
- ☐ _______ Other______________________

We accept Escribe and fax prescriptions. A faxable prescription form is available at amberpharmacy.com/providers/referral-forms/

REV.0421

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PRESCRIPTIONS

MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER FOR OFFICIAL PATIENT RECORDS)

Patient Last Name	Patient First Name	DOB
Address		
City	State	ZIP
Date of Issue		

Practice / Facility Name		
Practice Address		
City	State	ZIP
NPI #	DEA #	

PRESCRIPTION INFORMATION

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	DAW (Dispense as Written)
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

Total RXs ______

______________________________ ____ /____ /____

Prescriber Signature Date

______________________________ ____ /____ /____

Supervising Physician Signature (where required by state law) Date

The information contained in this document will become a legal prescription.* ***Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. *If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.*

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