CARDIOLOGY REFERRAL FORM

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

Patient Treatment Status: ☐ New to Therapy ☐ Therapy Restart ☐ Existing Treatment | Expected Therapy Start Date/Date Med Needed

Allergies ☐ NKDA ☐ Drug Allergies (please list) ☐ Other Allergies (please list)

Date of Diagnosis or Years with Condition | Current Smoker? ☐ Yes ☐ No

Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided: | Patient Height (cm/in): Weight (kg/lbs): Date Obtained:

If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No | Lab Values: Current LDL-C Date:
(Please attach a copy of patient's most recent lipid panel)

Previous Lipid-Lowering Treatments (please check all that apply) ☐ None

	Strength/Frequency	Dates of Therapy	Contraindications
☐ Atorvastatin (Lipitor)	_____mg/_____	mm/yy_____to_____	_____
☐ Ezetimibe (Zetia)	_____mg/_____	mm/yy_____to_____	_____
☐ Pravastatin (Pravachol)	_____mg/_____	mm/yy_____to_____	_____
☐ Rosuvastatin (Crestor)	_____mg/_____	mm/yy_____to_____	_____
☐ Simvastatin (Zocor)	_____mg/_____	mm/yy_____to_____	_____
☐ Pitavastatin (Livalo)	_____mg/_____	mm/yy_____to_____	_____
☐ Ezetimibe/Simvastatin (Vytorin)	_____mg/_____	mm/yy_____to_____	_____

Past Medical History Includes ☐ Myocardial Infarction ☐ Peripheral Arterial Disease ☐ Stable or Unstable Angina ☐ Stroke and Acute Coronary Syndrome ☐ Coronary/Arterial Revascularization ☐ Other _____

Other Lipid-Lowering Agents to be Used Concurrently w/ PCSK9 Treatment ☐ No ☐ Yes (please list)

Is the patient statin intolerant? ☐ No ☐ Yes (Intolerance Symptoms): ☐ Muscle Pain or Weakness ☐ Rhabdomyolisis ☐ Elevated CK ☐ Elevated LFTs ☐ Other: _____

Did symptoms reappear after statin re-challenge with a lower dose? ☐ Yes ☐ No

Any other contraindications to non-PCSK9 therapy for hypercholesterolemia? ☐ No ☐ Yes (please list)

Other/Concomitant Medications (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

Primary ICD-10 Code ☐ Code _____ Description _____ | Secondary ICD-10 Code ☐ Code _____ Description _____

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
☐ Leqvio	☐ 284 mg/1.5 mL PFS	☐ Initial Dose: Inject 284 mg SubQ initially and again at 3 months ☐ Maintenance Dose: Inject 284 mg SubQ every 6 months *(Note: should be administered by a healthcare professional)*	1	1
☐ Praluent®	☐ 75 mg Auto- Injector 2-Pack	☐ Inject 75 mg SubQ every 2 weeks	☐ 28-Day ☐ 84-Day	
	☐ 150 mg/mL Auto-Injector 2-Pack	☐ Inject 150 mg SubQ every 2 weeks ☐ Inject 300 mg SubQ every 4 weeks *(to administer a 300 mg dose, give two 150 mg injections consecutively at 2 different injection sites)*	☐ 28-Day ☐ 84-Day	
☐ Repatha™	☐ 140 mg PFS ☐ 140 mg Auto-Injector	☐ Inject 140 mg SubQ every 2 weeks ☐ Inject 420 mg (3x140 mg) SubQ every 4 weeks *(to administer a 420 mg dose, give three 140 mg injections consecutively at 3 different injection sites)* ☐ Inject 420mg (3x140mg) SubQ every 2 weeks *(to administer a 420mg dose, give three 140mg injections consecutively at 3 different injection sites)*	☐ 28-Day ☐ 84-Day	
	☐ 420 mg Pushtronex System	☐ Inject 420 mg SubQ once monthly *(via single-use, on-body infuser with prefilled cartridge over 9 minutes)* ☐ Inject 420 mg SubQ every 2 weeks *(via single-use, on body infuser with prefill cartridge over 9 minutes)*	☐ 30-Day ☐ 90-Day	

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

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

REV0222

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.*