

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) <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 _____	<input type="checkbox"/> None <input type="checkbox"/> Yes (Please indicate below): _____ _____ _____
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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)

NEW PATIENT CHECKLIST

Please use this checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment.

- List your full name and contact information (direct line, email) on the form.
- Provide all insurance information including copies of both medical and prescription cards.
- Provide most recent clinic notes/documentation of medical necessity.
- Include labs for LDL-C (drawn within the last 30 days) and Total Cholesterol: untreated values, current values and values on PCSK9 inhibitors (if currently treated with requested medication).
- Include names, strengths and dates of all tried and failed statins.
- List any special instructions pertaining to the patient.

Once you've checked all of the boxes above, please choose your preferred method of referring your patient.

1. **Fax** your referral to 877.645.7514.
2. **Call** us at 855.896.9254.
3. **E-prescribe** to Amber Pharmacy using your EMR.

When choosing options 2 or 3, please be sure to fax your supporting paperwork to 877.645.7514.



888.370.1724

www.amberpharmacy.com