CARDIOLOGY REFERRAL FORM

Amber PHARMACY
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)

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 ❑ 150 mg/ml 2-Pack	❑ Inject 75 mg SQ every 2 weeks ❑ 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) ❑ Inject 420 mg SQ once monthly (3 Syringes)	28 days 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.

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.

Amber PHARMACY

888.370.1724
www.amberpharmacy.com