

Patient Information  **IMPORTANT: Please Fax a Copy of Patient's Insurance Card (Front and Back)**

Last Name		First Name		Home Phone		Work/Mobile Phone	
Home Address				City		State	ZIP
Shipping Address (if different from above)				City		State	ZIP
Social Security Number	Date of Birth	Gender (M/F)	Primary Caregiver Name and Phone			Emergency Contact Name and Phone	

Clinical Assessment Please FAX recent clinical notes, labs and tests with the prescription to expedite the Prior Authorization process

Diagnosis

ICD-9 Codes: 272.0 (Pure Hypercholesterolemia) 272.2 (Mixed Hyperlipidemia) 272.4 (Other Hyperlipidemia)

ICD-10 Codes: (When implemented, use ICD-10 codes)

E78.0 (Pure Hypercholesterolemia) E78.2 (Mixed Hyperlipidemia) E78.4 (Other Hyperlipidemia) E78.5 (Unspecified Hyperlipidemia)

ASCVD-Specific Code (ICD-9/ICD-10): _____

Previous Lipid-Lowering Treatments: None Yes (Check all that apply)

	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 _____

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:** _____

Healthcare Provider Information:

Practice/Facility Name		Physician First and Last Name*		Phone*		Fax	
Address*				City*		State*	ZIP*
Physician NPI#*		Nurse/Key Contact		Phone or Pager #		Email	

Additional Information

Today's Date	Delivery Date	Deliver to:	Special Instructions
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Medication Dose/Strength Directions for Use Quantity Refills

Medication	Dose/Strength	Directions for Use	Quantity	Refills
<input type="checkbox"/> Praluent® <input type="checkbox"/> Pre-Filled Pen <input type="checkbox"/> Pre-Filled Syringe	<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	

Physician Signature: _____ **DAW (Dispense as Written) 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.

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