Cardiology Referral Form

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

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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
❑ 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 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

Medication	Dose/Strength	Directions for Use	Quantity	Refills
❑ **Praluent®** ❑ Pre-Filled **Pen** ❑ Pre-Filled **Syringe**	❑ 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	

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.