# Cardiovascular Referral Form

Please fax to

866.279.3315

| | |
|---|---|
| Patient Name: | Primary Ins: |
| DOB: | BinRx/PCN#: |
| SSN: | ID#: |
| Address: | Group#: |
| City/ST/Zip: | Phone#: |
| Phone#: | Secondary Ins: |
| Emergency contact# | Sex: M F |
| Diagnosis: | Height: |
| Weight: | Allergies: |

## Clinical Info

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 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 _____

Achieved Max Tolerated Statin Dose? ☐ Yes _____ ☐ No_____

Any other contraindications to non-PCSK9 therapy for hypercholesterolemia? _____

Lab Values: ☐ LDL-C _____mg/dl Date: _____

Repatha/Praluent was prescribed by or in consultation with a cardiologist, an endocrinologist, and/or a physician who specializes in the management of cardiovascular disease &/or lipid disorders ☐ Yes:_____ ☐ No

Indicate One Primary Diagnosis:

- ☐ E78.0 Pure Hypercholesterolemia (HeFH and HoFH)
- ☐ E78.2 Mixed Hyperlipidemia
- ☐ E78.5 Other & Unspecified Hyperlipidemia
- ☐ Other: _____

Indicate One Secondary Diagnosis

- ☐ I21.__ Acute Myocardial Infarction
- ☐ 122.__ Subsequent Myocardial Infarction
- ☐ I25.2 Old Myocardial Infarction
- ☐ I20.8 Other & Unspecified Angina Pectoris
- ☐ I25.__Other Forms of Chronic Ischemic Heart Disease
- ☐ I25.10 ASCVD, Unspecified
- ☐ I65.__ Occlusion & Stenosis of Precerebral Arteries
- ☐ I6_.__ Occlusion of Cerebral Arteries (CVA)
- ☐ G45.__ Transient Cerebral Ischemia (TIA)
- ☐ I67.__ Other & Ill-Defined Cerebrovascular Disease
- ☐ I69.__ History of Stroke with Residuals
- ☐ I70.__ Atherosclerosis
- ☐ I73.9 Peripheral Vascular Disease, Unspecified
- ☐ Other

## Prescription Info

| | | | |
|---|---|---|---|
| Praluent | ☐ Pre-filled Pen<br>☐ Pre-filled Syringe | ☐ Inject 75mg subcutaneously every 2 weeks (quantity: 2)<br>☐ Inject 150 mg subcutaneously every 2 weeks (quantity: 2) | Refills: __ |
| Repatha | ☐ 140 mg/mL SureClick autoinjector<br>☐ 140 mg/mL pre-filled syringe<br>☐ Pushtronex 420mg | ☐ Inject 140mg subcutaneously every 2 weeks (quantity: 2)<br>☐ Administer 420mg/3.5ml subcutaneously using a Pushtronex system (on-body infusor with prefilled cartridge) once monthly | Refills: __ |

**Deliver to:**

Patient's home ____ MD's Office ____ First dose to MD ____

**Training:**

Pharmacy Training ____ Physician Training in office ___

*****By signing this form and utilizing our services, you are authorizing our employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.**

**Physician Signature DAW** | **Substitution Allowed** | **Date**

| | | |
|---|---|---|
| Physician Name: | Office Contact: | |
| Address: | Phone: | |
| Address: | Fax: | |
| City/St/Zip: | NPI: | DEA: |

*** IMPORTANT NOTICE: This fax is intended to be delivered to the name addressee. It contains material confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify sender immediately.