



Specialty Pharmacy With A Personal Touch
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Cardiovascular Referral Form
Please fax to
855.291.7860

4284 New Getwell Road
Memphis, TN 38118
p 855.394.2930

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: <input type="checkbox"/> None <input type="checkbox"/> Yes (check all that apply) <table border="0"> <tr> <th style="text-align: left;">Strength/Freq</th> <th style="text-align: left;">Dates of Therapy</th> </tr> <tr> <td><input type="checkbox"/> atorvastatin _____ mg/_____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> ezetimibe _____ mg/_____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> pravastatin _____ mg/_____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> rosuvastatin _____ mg/_____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> simvastatin _____ mg/_____</td> <td>mm/yy _____ to _____</td> </tr> <tr> <td><input type="checkbox"/> other _____ mg/_____</td> <td>mm/yy _____ to _____</td> </tr> </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 _____	Other Lipid-Lowering Agents to be Used Concurrently with PCSK9 Treatment: <input type="checkbox"/> None <input type="checkbox"/> Yes (please indicate below) _____ _____ _____
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 _____														

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: <input type="checkbox"/> E78.0 Pure Hypercholesterolemia (HeFH and HoFH) <input type="checkbox"/> E78.2 Mixed Hyperlipidemia <input type="checkbox"/> E78.5 Other & Unspecified Hyperlipidemia <input type="checkbox"/> Other: _____	Indicate One Secondary Diagnosis <input type="checkbox"/> I21.____ Acute Myocardial Infarction <input type="checkbox"/> I22.____ Subsequent Myocardial Infarction <input type="checkbox"/> I25.2 Old Myocardial Infarction <input type="checkbox"/> I20.8 Other & Unspecified Angina Pectoris <input type="checkbox"/> I25.____ Other Forms of Chronic Ischemic Heart Disease <input type="checkbox"/> I25.10 ASCVD, Unspecified <input type="checkbox"/> I65.____ Occlusion & Stenosis of Precerebral Arteries <input type="checkbox"/> I6.____ Occlusion of Cerebral Arteries (CVA) <input type="checkbox"/> G45.____ Transient Cerebral Ischemia (TIA) <input type="checkbox"/> I67.____ Other & Ill-Defined Cerebrovascular Disease <input type="checkbox"/> I69.____ History of Stroke with Residuals <input type="checkbox"/> I70.____ Atherosclerosis <input type="checkbox"/> I73.9 Peripheral Vascular Disease, Unspecified <input type="checkbox"/> Other
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Prescription Info

Praluent <input type="checkbox"/> Pre-filled Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> Inject 75mg subcutaneously every 2 weeks (quantity: 2) <input type="checkbox"/> Inject 150 mg subcutaneously every 2 weeks (quantity: 2)	Refills: ____
Repatha <input type="checkbox"/> 140 mg/mL SureClick autoinjector <input type="checkbox"/> 140 mg/mL pre-filled syringe <input type="checkbox"/> Pushtronex 420mg	<input type="checkbox"/> Inject 140mg subcutaneously every 2 weeks (quantity: 2) <input type="checkbox"/> 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 EntrustRx and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician's Signature DAW		Substitution Allowed	Date
Physician's 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.