



Specialty Pharmacy With A Personal Touch
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Cardiovascular Referral Form

Please fax to
866.279.3315

402 Wilkins Wise Road STE 38
Columbus, MS 39705
p 866.279.3314

| | |
|--------------------|----------------|
| 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 |
|---------------------------------------|---------------|------------------|
| <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:
 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
- I22. ___ 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 | <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 | |

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: |

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