EntrustRx
Specialty Pharmacy With A Personal Touch
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Cardiovascular Referral Form

Please fax to
855.273.3925

2001 Campbell Station Pky STE A5
Spring Hill, TN 37174
p 855.273.3924

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
☐ 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	☐ Pre-filled Pen ☐ Pre-filled Syringe	☐ Inject 75mg subcutaneously every 2 weeks (quantity: 2) ☐ Inject 150 mg subcutaneously every 2 weeks (quantity: 2)	Refills: __
Repatha	☐ 140 mg/mL SureClick autoinjector ☐ 140 mg/mL pre-filled syringe ☐ Pushtronex 420mg	☐ Inject 140mg subcutaneously every 2 weeks (quantity: 2) ☐ 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:

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