Procare PHARMACY

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Hypercholesterolemia Prescription Referral Form (Form 11B)

Date Medication Needed: _____ **Ship To:** Patient's Home Prescriber's Office Injection training by pharmacy?

1: Patient Information

Patient Name: **Birthdate:** _____ **Sex:** Male Female **Height:** **Weight:** _____ lbs. kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ City: _____ State: ZIP: _____

Alt. Caregiver Name: **Phone:** _____ **Comorbidities:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Clinical Information

ICD-10 Codes and Diagnosis

Primary ICD-10 (must select one)

- E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)
- E78.2 Mixed Hyperlipidemia
- E78.4 Other Hyperlipidemia
- E78.5 Hyperlipidemia, unspecified

Secondary ICD-10 (select all that apply)

- 120.0 Unstable Angina
- 120.9 Angina Pectoris
- 121.___ Acute Myocardial Infaction
- 122.___ Subsequent Myocardial Infarction
- 125.___ Chronic Ischemic Heart Disease
- 163.___ Cerebral Infarction
- 165.___ Occlusion and stenosis of Cerebral Arteries, Intracranial
- 167.___ Other Cerebrovascular Diseases

Other, Specify ICD-10 _____

Previous Treatment (select all that apply)

Atorvastatin (Lipitor)	10mg	20mg	40mg	80mg	
Rosuvastatin (Crestor)	5mg	10mg	20mg	40mg	
Simvastatin (Zocor)	5mg	10mg	20mg	40mg	80mg
Ezetimibe (Zetia)	10mg				

Other statin/lipid lowering agent(s): _____

Current therapy: Dose: Date Started: _____

Achieved maximum tolerated statin dose?

Lab Results:

please attach a copy of patients most recent lipid panel

LDL-C mg/ml Date _____

Intolerance to statins (list medications and dose failed): _____

_____

_____

Rhabdomyalosis Myositis Myalgia

Baseline LFT's: _____

3: Prescription Information

Medication	Strength	Directions	Qty.	Refills
Praluent®	75 mg/mL Pen 75 mg/mL PFS 150 mg/mL Pen 150 mg/mL PFS	Inject subcutaneously every 2 weeks Other: _____	1 month supply Other: _____	
Repatha™	140 mg/mL PFS 140 mg/mL SureClick®	Inject 140 mg sub-Q every 2 weeks Inject 420 mg sub-Q every 4 weeks	1 pack = 1 x 140 mg/mL PFS 1 pack = 1 x 140 mg/mL SureClick® 2 pack = 2 x 140 mg/mL SureClick® 3 pack = 3 x 140 mg/mL SureClick®	

4: Injection Training

Patient received injection training | Prescriber's office to provide injection training | Avella to coordinate injection training

5: Prescriber Information

Prescriber Name: office contact: _____

preferred method of contact: phone fax email preferred contact persons email: _____

ship to: patient office alternate _____ (shipping address) _____ (street) _____ (city) _____ (state) _____ (zip)

office address: _____ (street, suite, city, state, zip)

phone: fax: _____ NPI: _____

PRIOR AUTHORIZATION APPLICATION TO INSURANCE AND PATIENT SUPPORT PROGRAM ARE AVAILABLE AT PROCARE PHARMACY

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____