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Hypercholesterolemia Referral Form



Ship to: Patient Prescriber Pick Up (location): _____ Date Needed: _____ Need Nurse Need Training

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name:			Prescriber Name:		
Address:			NPI#:		DEA#
City:	State:	Zip:	Address:		
Phone: ()	Alt Phone: ()		City:	State:	Zip:
Emergency Contact Name:			Phone: ()		Fax: ()
Emergency Contact Phone: ()			Nurse/Key Office Contact:		
Patient Soc. Sec#:	Date of Birth: / /				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight	lbs/kg	Height		
Allergies:					

CLINICAL INFORMATION (Please FAX recent clinical notes, labs, tests & current medication list with prescription)

Diagnosis <input type="checkbox"/> E78.0 Pure Hypercholesterolemia (including HeFH & HoFH) <input type="checkbox"/> E78.2 Mixed Hyperlipidemia <input type="checkbox"/> E78.4 Other Hyperlipidemia <input type="checkbox"/> E78.5 Hyperlipidemia, unspecified <input type="checkbox"/> Other _____ Baseline LDL-C _____ mg/dL Date: _____ Current LDL-C _____ mg/dL Date: _____	Prior Treatment History (select all that apply & please attach list if necessary) Atorvastatin (Lipitor) 10mg 20mg 40mg 80mg Dates: _____ Rosuvastatin (Crestor) 5mg 10mg 20mg 40mg Dates: _____ Simvastatin (Zocor) 5mg 10mg 20mg 40mg 80mg Dates: _____ Pravastatin (Pravachol) 10mg 20mg 40mg 80mg Dates: _____ Ezetimibe (Zetia) 10mg Dates: _____ Other statin/lipid lowering agent(s): _____ Dates: _____ Does patient have any contraindications or intolerances to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name medication and describe contraindication or reaction? _____
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Past Medical History Includes:

- Myocardial infarction
- Coronary/arterial revascularization (PTCA, CABG)
- Stroke or transient ischemic attack (TIA)
- Peripheral arterial disease
- Stable or unstable angina
- Chronic Ischemic Heart Disease Cerebral Infarction
- De-compensated liver disease Acute Liver Disease
- Rhabdomyolysis Myalgia Myositis

Current Therapy: Product & Dose: _____ Start Date: _____
 Will patient be discontinuing any current medication(s) before starting new medication? Yes No

Labs: please include copy of most recent lab work results

ALT: _____ Date: _____ AST: _____ Date: _____
 Hgb _____ Date: _____ Platelet: _____ Date: _____
 Albumin _____ Date: _____ Serum creatinine: _____ Date: _____
 Creatine Kinase: _____ Date: _____

Diagnosis confirmed by:

- WHO/Dutch Lipid Clinic Network Familial Hypercholesterolemia diagnostic criteria score of _____.
- Other _____

For Atherosclerotic Cardiovascular Disease (ASCVD):

ASCVD Pooled Cohort Risk Assessment Score (if applicable): _____
OR
 Framingham Risk Score (if applicable): _____

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Praluent® (alirocumab)	<input type="checkbox"/> 75mg/mL Pen	<input type="checkbox"/> Inject 75mg SC every 2 weeks	<input type="checkbox"/> 2 x 75mg/mL doses	
	<input type="checkbox"/> 75mg/mL PFS			
	<input type="checkbox"/> 150mg/mL Pen	<input type="checkbox"/> Inject 150mg SC every 2 weeks	<input type="checkbox"/> 2 x 150mg/mL doses	
	<input type="checkbox"/> 150mg/mL PFS			
Repatha™ (evolocumab)	<input type="checkbox"/> 140mg/mL PFS	<input type="checkbox"/> Inject 140mg SC every 2 weeks	<input type="checkbox"/> 2 x 140mg/mL doses	
	<input type="checkbox"/> 140mg/mL SureClick®	<input type="checkbox"/> Inject 420mg SC every 4 weeks	<input type="checkbox"/> 3 x 140mg/mL doses	
	<input type="checkbox"/> 420mg/3.5mL Pushtronex™	<input type="checkbox"/> Inject 420mg SC every 4 weeks	<input type="checkbox"/> 1 x 420mg/3.5mL dose	
Other		<input type="checkbox"/>		
Other		<input type="checkbox"/>		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.

Date: _____

DISPENSE AS WRITTEN

MAY SUBSTITUTE