Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Hypercholesterolemia Referral Form

1204 SE 28th St, Suite 2
Bentonville, AR 72712
Phone: 844-414-5805
Fax: 855-422-2400

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: ❑ Male ❑Female **Weight** lbs/kg Height	
Allergies:	

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

Diagnosis
❑E78.0 Pure Hypercholesterolemia (including HeFH & HoFH)
❑E78.2 Mixed Hyperlipidemia
❑E78.4 Other Hyperlipidemia
❑E78.5 Hyperlipidemia, unspecified
❑Other____

Baseline LDL-C_______________mg/dL Date:________________
Current LDL-C _______________mg/dL Date:________________

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

Diagnosis confirmed by:
❑WHO/Dutch Lipid Clinic Network Familial Hypercholesterolemia diagnostic criteria score of ______________.
❑Other_______________________________________

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? ❑Yes ❑No
If yes, please name medication and describe contraindication or reaction? ____________________________________

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:_______________________

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)*	❑ 75mg/mL Pen ❑ 75mg/mL PFS ❑ 150mg/mL Pen ❑ 150mg/mL PFS	❑ Inject 75mg SC every 2 weeks ❑ Inject 150mg SC every 2 weeks ❑ Inject 300mg SC every 4 weeks	❑ 2 x 75mg/mL doses ❑ 2 x 150mg/mL doses	
Repatha™ *(evolocumab)*	❑ 140mg/mL PFS ❑ 140mg/mL SureClick® ❑ 420mg/3.5mL Pushtronex™	❑ Inject 140mg SC every 2 weeks ❑ Inject 420mg SC every 4 weeks ❑ Inject 420mg SC every 4 weeks	❑ 2 x 140mg/mL doses ❑ 3 x 140mg/mL doses ❑ 1 x 420mg/3.5mL dose	
Other	___________________	❑ ____		
Other	___________________	❑ ____		

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**