CARDIOLOGY ENROLLMENT FORM

DATE:________________________ SHIP TO:
DATE NEEDED: __________________ ☐ PATIENT ☐ OFFICE

PATIENT INFO

NAME__________________________ E-MAIL ____________________ Spanish Speaking: ☐ Yes ☐ No DOB________________ ☐ MALE ☐ FEMALE

ADDRESS__________________________________ CITY______________________ STATE_______ ZIP____________

HOME TELEPHONE _______________________ MOBILE PHONE_______________________ SS#__________________

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK) also FAX clinical notes, labs, and test with this referral form

CLINICAL INFORMATION

DIAGNOSIS CODE

☐ **Date of Diagnosis:** ______________________________

☐ **E78.0 Pure hypercholesterolemia - Check one of the following sub-diagnoses:**

- ☐ LDL not controlled despite max-tolerated statin dose
- ☐ Statin-intolerant (list reason) ________________________

☐ **E78.01 Familial Hypercholesterolemia:** ☐ homozygous ☐ heterozygous

☐ **ASCVD (Please indicate history/risk factors)** ______________________________

____

☐ **Other:** ______________________________________

Past Medical History:
Please indicate if the patient has experienced any of the following events:

- ☐ Myocardial infarction
- ☐ Unstable Angina requiring hospitalization
- ☐ Heart failure requiring hospitalization
- ☐ Coronary revascularization
- ☐ Stroke
- ☐ TIA

Patient Risk Factors:
Please indicate if the patient has any risk factors:

- ☐ Hypertension
- ☐ Diabetes Mellitus
- ☐ Metabolic syndrome
- ☐ Current smoker
- ☐ Family history of premature CAD
- ☐ Known familial hypercholesterolemia

Height:_______ inches Weight:_______ ☐ kg ☐ lb

Allergies? ☐ Latex ☐ Other:________________________ ☐ NKDA

LABS: LDL: ___________ HDL:________________

Triglycerides:_________________ Lipoprotein a: ______________

Total Cholesterol: ______________ Date of Labs: ______________

Concomitant Meds: ____

____

PRIOR FAILED MEDICATIONS:

☐ **Crestor® (rosuvastatin)**	☐ **Lipitor® (atorvastatin)**	☐ **Zetia® (ezetimibe)**	☐ **Zocor® (simvastatin)**
Length of Treatment_______ to _______	Length of Treatment_______ to _______	Length of Treatment_______ to _______	Length of Treatment_______ to _______
Reason for Discontinuing ____________	Reason for Discontinuing ____________	Reason for Discontinuing ____________	Reason for Discontinuing ____________

Medication________________________	Medication________________________
Length of Treatment ___________ to ___________	Length of Treatment ___________ to ___________
Reason for Discontinuing __________________	Reason for Discontinuing __________________

PCSK9 INHIBITORS

DRUG NAME	DOSAGE FORM / STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Praluent™** (alirocumab)	☐ 75mg/ml Prefilled PEN ☐ 75mg/ml Prefilled SYRINGE ☐ 150mg/ml Prefilled PEN ☐ 150mg/ml Prefilled SYRINGE	☐ Inject 1 pen/PFS SC every other week. ☐ Inject 300mg (150mg x2 pens/syringes) SC every 4 weeks ☐ Other: ______________________	☐ 2 pens / syringes ☐ Other:_________ ______________	☐ 11 ☐ ______
☐ **Repatha®** (evolocumab)	☐ 140mg/ml Autoinjector PEN ☐ 140mg/ml Prefilled SYRINGE	☐ Inject 140mg (1 pen/PFS) SC every other week. ☐ Inject 420mg (3 pens/PFS) SC once a month. ☐ Other: ______________________	☐ 2 pens / syringes ☐ 3 pens / syringes ☐ Other:_________ ______________	☐ 11 ☐ ______
☐ **Repatha® Pushtronex™**	☐ 420mg/3.5ml Pushtronex™	☐ Administer 420 mg subcutaneously via on-body infusor over 9 minutes every 4 weeks ☐ Other: ______________________	☐ 1 x 420 / 3.5ml Pushtronex™ ☐ Other:_________ ______________	☐ 11 ☐ ______

OTHER MEDICATIONS

DRUG NAME	DOSAGE FORM / STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Crestor® (rosuvastatin)				
Lipitor® (atorvastatin)				
Zetia® (ezetimibe)				
Zocor® (simvastatin)				

INJECTION TRAINING ☐ **Patient has received injection training** ☐ **Physician Office to provide injection training** ☐ **Pharmacy to provide injection training**

PRESCRIBER INFORMATION

Prescriber's Name: ______________________________ Contact Person:____________________

Telephone: ______________________ Fax:____________________ Email:____________________

Office Address: ______________________________ City:________________ State: ______ Zip:________

NPI # : _______________ DEA # : _______________ TAX ID # : _______________ Medicaid Provider # :__________________

______________________ ___________ * ______________________________

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

©ReCept, LP All rights Reserved

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

© REF--Cardiology-E-