**Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

AccuSERV PHARMACY

# HYPERCHOLESTEROLEMIA REFERRAL FORM

**Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821**
**FAX: 877-526-8823**

Start Date

Ship To: ☐ Patient ☐ Office ☐ **Other**

## 1. Patient Information:

**Please fax front and back copy of the insurance card (Prescription and Medical)**

Patient: _____ Male / Female DOB: _____ Soc. Sec. #_____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

## 2. Clinical Information:

**Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization**

### ICD-10 Codes and Diagnosis:

☐ **E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)** ☐ **E78.2 Mixed Hyperlipidemia**
☐ **E78.4 Other Hyperlipidemia** ☐ **E78.5 Hyperlipidermia, 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 Cerebrovasular 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**
☐ **Ezetimib(Zetia)** ☐ **10mg**
☐ **Other statin/lipid lowering agents:**_____
**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 & dose failed):**____
_____
☐ **Rhabdomyalosis** ☐ **Myositis** ☐ **Myalgia**
☐ **Baseline LFT's**_____

## 3. Prescription Information:

**If you need a medication not listed please contact us**

| Medication | Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ **Praluent®** | ☐ **75mg/mL Pens**<br>☐ **75mg/mL PFS**<br>☐ **150mg/mL Pen**<br>☐ **150mg/mL PFS** | ☐ **Inject Subcutaneously every 2 weeks**<br>☐ **Other:**_____ | ☐ **1 month supply**<br>☐ **Other:**_____ | |
| ☐ **Repatha ™** | ☐ **140 mg/mL PFS**<br>☐ **140mg/ml SureClick** | ☐ **Inject 140mg sub-Q every 2 weeks**<br>☐ **Inject 420mg sub-Q every 4 weeks** | ☐ **1 pack= 1x140 mg/mL PFS**<br>☐ **1 pack= 1x140 mg/mL SureClick**<br>☐ **2 pack= 2x140 mg/mL SureClick**<br>☐ **3 pack=3x140 mg/ml SureClick** | |
| | | | | |

## 4. Prescriber and Shipping Information

Prescriber (print):_____ Office Contact: _____

**Preferred method of contact:** ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:**_____

**Office Address:**_____

**Phone:**_____**fax:**_____**NPI:**_____**DEA:**_____

**Prescriber's Signature:**_____**Date:**_____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. **(NO STAMPS)**

## 5. Patient Support Programs (optional):

**Please sign below to enroll in the pharmaceutical company assisted patient support program**

**Patient Signature:**_____**Date:**_____

## 6. Insurance Information:

**Please fax a copy of the insurance card (front & back)**

 **Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.**