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** ☐**75mg/mL PFS** ☐**150mg/mL Pen** ☐**150mg/mL PFS**	☐ **Inject Subcutaneously every 2 weeks** ☐ **Other:**______________	☐ **1 month supply** ☐ **Other:**__________	
☐ **Repatha ™**	☐**140 mg/mL PFS** ☐**140mg/ml SureClick**	☐ **Inject 140mg sub-Q every 2 weeks** ☐ **Inject 420mg sub-Q every 4 weeks**	☐**1 pack= 1x140 mg/mL PFS** ☐**1 pack= 1x140 mg/mL SureClick** ☐**2 pack= 2x140 mg/mL SureClick** ☐**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)

***IMPORTANT NOTICE:this fax is intended to be delivered only to the named address. It contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and distory this document immediately. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.**