**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

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

Diagnosis: Codes: / ICD-10: _____

Hypercholesterolemia *(MUST select at least one)*

☐ E78.0 Pure hypercholesterolemia
☐ E78.2 Mixed hyperlipidemia
☐ E78.4 Other hyperlipidemia

☐ **Secondary ICD-10:** _____

_____

Previous/Current Therapies: _____

Drug Name: _____Dose: _____Date started: _____

_____

_____

Lab Results:
(Please attach a copy of patients' most recent lipid panel)

LDL-C _____mg/ml

Date: _____

3. Prescription Information: If you need a medication not listed please contact us

Medication	Strength	Directions	Quantity	Refills
☐ Praluent®	☐ 75 mg/mL Pen ☐ 75 mg/mL PFS	☐ Inject 75 mg sub-Q every 2 weeks	☐ 1 carton = 2 X 75 mg/mL	
	☐ 150 mg/mL Pen ☐ 150 mg/mL PFS	☐ Inject 150 mg sub-Q every 2 weeks	☐ 1 carton = 2 x 150 mg/mL	
☐ Repatha™	☐ 140 mg/mL PFS ☐ 140 mg/mL SureClick®	☐ Inject 140 mg sub-Q every 2 weeks ☐ Inject 420 mg Sub-Q every 4 weeks	☐ 1 pack = 1 x 140 mg/mL PFS ☐ 1 pack = 2 x 140 mg/mL SureClick® ☐ 2 pack = 4 x 140 mg/mL SureClick® ☐ 3 pack = 6 x 140 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.