

Date: ____/____/____ Needs by Date: _____

Language: _____ Nursing Instruction Required

HYPERCHOLESTEROLEMIA REFERRAL FORM

Ship to: Patient MD Office

Prescriber's Name: _____ DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: ____/____/____ Gender: F M

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

<p>ICD-10 Codes and Diagnosis</p> <p>Primary ICD-10 (must select one)</p> <p>E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)</p> <p>E78.2 Mixed Hyperlipidemia</p> <p>E78.4 Other Hyperlipidemia</p> <p>E78.5 Hyperlipidemia, unspecified</p> <p>Secondary ICD-10 (select all that apply)</p> <p>120.0 Unstable Angina</p> <p>120.9 Angina Pectoris</p> <p>121. ___ Acute Myocardial Infarction</p> <p>122. ___ Subsequent Myocardial Infarction</p> <p>125. ___ Chronic Ischemic Heart Disease</p> <p>163. ___ Cerebral Infarction</p> <p>165. ___ Occlusion and stenosis of Cerebral Arteries, Intracranial</p> <p>167. ___ Other Cerebrovascular Diseases</p> <p>Other, Specify ICD-10 _____</p>	<p>Previous Treatment (select all that apply)</p> <table border="0"> <tr> <td>Atorvastatin (Lipitor)</td> <td>10mg</td> <td>20mg</td> <td>40mg</td> <td>80mg</td> </tr> <tr> <td>Rosuvastatin (Crestor)</td> <td>5mg</td> <td>10mg</td> <td>20mg</td> <td>40mg</td> </tr> <tr> <td>Simvastatin (Zocor)</td> <td>5mg</td> <td>10mg</td> <td>20mg</td> <td>40mg 80mg</td> </tr> <tr> <td>Ezetimibe (Zetia)</td> <td>10mg</td> <td></td> <td></td> <td></td> </tr> </table> <p>Other statin/lipid lowering agent(s): _____</p> <p>Current therapy: _____ Dose: _____ Date Started: _____</p> <p>Achieved maximum tolerated statin dose? _____</p> <p>Lab Results:</p> <p>please attach a copy of patients most recent lipid panel</p> <p>LDL-C _____ mg/ml Date _____</p> <p>Intolerance to statins (list medications and dose failed): _____</p> <p>_____</p> <p>Rhabdomyolysis Myositis Myalgia</p> <p>Baseline LFT's: _____</p>	Atorvastatin (Lipitor)	10mg	20mg	40mg	80mg	Rosuvastatin (Crestor)	5mg	10mg	20mg	40mg	Simvastatin (Zocor)	5mg	10mg	20mg	40mg 80mg	Ezetimibe (Zetia)	10mg			
Atorvastatin (Lipitor)	10mg	20mg	40mg	80mg																	
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Simvastatin (Zocor)	5mg	10mg	20mg	40mg 80mg																	
Ezetimibe (Zetia)	10mg																				

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QTY.	REFILLS
Praluent *	75 mg/mL Pen 75 mg/mL PFS 150 mg/mL Pen 150 mg/mL PFS	Inject subcutaneously every 2 weeks Other: _____	1 month supply Other: _____	
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 = 1 x 140 mg/mL SureClick® 2 pack = 2 x 140 mg/mL SureClick® 3 pack = 3 x 140 mg/mL SureClick®	

Physician Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile 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 center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter 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.

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