

HYPERCHOLESTEROLEMIA PRESCRIPTION FORM

Phone: (844) 446-0808 | Fax: (844) 446-0809

Ship To: Patient Physician
 All supplies including Syringes and needles will be dispensed if needed.

Patient Name (Required):		Physician Name:	
Home Phone:	Cell Phone:	LIC#:	DEA #:
Address:		NPI #:	Specialty:
Emergency Contact Name: (Required):		Practice Name/Hospital:	
Emergency Contact Phone #: (Required):		Address:	
Patient Soc. Sec #:	Allergies: <input type="checkbox"/> NKA	City:	State: Zip:
DOB (Required):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> Kg	Physician's Phone: Physician's Fax:
<input type="checkbox"/> See attached demographic sheet	Height: BSA:	Nurse/Key Office Contact:	

INSURANCE INFORMATION | Please Complete or Attach Copies (front and back) of cards

Primary Ins:	Secondary Ins:	Rx Card (PBM):	Card Holder First Name:
City: State:	City: State:	PBM BIN:	Last Name:
Plan #:	Plan #:	City: State:	Employer:
Group #:	Group #:	Group #:	ID#:
Phone: ()	Phone: ()	Phone: ()	Group #:

DIAGNOSIS INFORMATION (choose one) | Please FAX clinical notes, Labs, Tests with the prescription

Primary ICD-10: Hypercholesterolemia HEFH (Pure) Hypercholesterolemia HOFH (Pure) Mixed Hyperlipidemia Hyperlipidemia, unspecified

Secondary ICD-10: 120.0 Unstable Angina 120.9 Angina Pectoris 121.____Acute Myocardial Infarction 122.____Subsequent Myocardial Infarction

125.____Chronic Ischemic Heart Disease 163.____Cerebral Infarction 165.____Occlusion and stenosis of Cerebral Arteries, Intracranial 167.____Other Cerebrovascular Diseases Other, ICD-10 (ICD-10 Code and description) _____

PREVIOUS TREATMENT (choose one)

ATORVASTATIN (Lipitor) 10mg 20mg 40mg 80mg SIMVASTATIN (Zocor) 5mg 10mg 20mg 40mg 80mg EZETIMIBE (ZETIA) 10mg

ROSUVASTATIN (Crestor) 5mg 10mg 20mg 40mg OTHER STATIN/LIPID LOWERING AGENT(S): _____

Current therapy: _____ Dose: _____ Date Started: _____ Achieved maximum tolerated stain dose? _____

Lab Results: please attach a copy of patients most recent lipid panel LDL-C _____ mg/ml Date _____

Intolerance to statins (list medications and dose failed): _____

RHABDOMYALOSIS MYOSITIS MYALGIA BASELINE LFT's: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> REPATHA®	<input type="checkbox"/> 140 mg/mL SureClick® <input type="checkbox"/> Pushtronex™ system <input type="checkbox"/> 140 mg/mL PFS	<input type="checkbox"/> Inject 140mg sub-Q every 2 weeks <input type="checkbox"/> Inject 420mg sub-Q once monthly	<input type="checkbox"/> 1 Pack = 1 x 140 mg/mL SureClick® <input type="checkbox"/> 2 Pack = 2 x 140 mg/mL SureClick® <input type="checkbox"/> 3 Pack = 3 x 140 mg/mL SureClick® <input type="checkbox"/> 1 Pack = 1 x 140 mg/mL PFS	
<input type="checkbox"/> OTHER				

INJECTION TRAINING (choose one)

<input type="checkbox"/> Patient received injection training	<input type="checkbox"/> Prescriber's office to provide injection training	<input type="checkbox"/> TruCare to coordinate injection training
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of Medications Prescribed: _____

Physician's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practitioner. Prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Pursuant to OH/MO/VT law, only 1 medication is permitted per order form. Prescribers are reminded patients may choose any pharmacy of their choice.tcv11416