TruCare PHARMACY

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

HYPERCHOLESTEROLEMIA PRESCRIPTION FORM

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: ☐ NKA	City: State: Zip:	
DOB (Required):	Sex: ☐ M ☐ F Weight: ☐ lbs. ☐ Kg	Physician's Phone:	Physician's Fax:
☐ **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 ☐ Hypercholesterolemia HOFH ☐ Mixed Hyperlipidemia ☐ E78.5 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
☐ **PRALUENT®**	☐ 75 mg/mL Pen ☐ 75 mg/mL PFS ☐ 150 mg/mL Pen ☐ 150mg/mL PFS	☐ Inject subcutaneously every 2 weeks ☐ Other:_____	☐ One Month Supply ☐ Other:_____	
☐ **OTHER**				

INJECTION TRAINING (choose one)

☐ Patient received injection training	☐ Prescriber's office to provide injection training	☐ TruCare to coordinate injection training

# 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 practioner. 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