Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to pharmacy.

Hypercholesterolemia

Referral for Medication and Patient Management Program

Phone: 877.385.0535
Fax: 877.326.2856

Please fax a copy (front and back) of all the patient's pharmacy and medical insurance cards as well as any relevant clinical notes/documents

Patient Demographics

Name ______ Sex ☐M ☐F
DOB ______ SSN ______
Phone ______ 2nd Phone ______
Address ______ Apt/Suite ______
City, State, ZIP ______
Primary language, if other than English ______

Provider Information

Prescriber ______
NPI ______ DEA ______
Practice Name ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______ Key contact ______

This is a ☐ New Rx ☐ Refill

Training by ☐ Prescriber's office ☐ Pharmacy to facilitate ☐ Not needed

Ship first fill to ☐ Prescriber's office ☐ Patient ☐ Other ______

Clinical Information

Please provide one primary and one or more secondary ASCVD ICD-10 codes

Primary diagnosis *(select one)*
- ☐ E78.0 Pure hypercholesterolemia, unspecified
- ☐ E78.01 Familial hypercholesterolemia
- ☐ E78.2 Mixed hyperlipidemia
- ☐ E78.4 Other hyperlipidemia
- ☐ E78.5 Hyperlipidemia, unspecified
- ☐ Other ______

Secondary diagnosis *(select all that apply)*
- ☐ G45.9 Transient cerebral ischemic attack, unspecified
- ☐ G46. ____ Vascular syndromes
- ☐ I20.0 Unstable angina
- ☐ I20.9 Angina pectoris, unspecified
- ☐ I21. ____ Subsequent myocardial infarction
- ☐ I25. ____ Chronic ischemic heart disease
- ☐ I63. ____ Cerebral infarction
- ☐ I65. ____ Occlusion and stenosis of cerebral arteries, external
- ☐ I66. ____ Occlusion and stenosis of cerebral arteries, intracranial
- ☐ I67. ____ Other cerebrovascular diseases
- ☐ I70. ____ Atherosclerosis
- ☐ I73.9 Peripheral vascular disease, unspecified
- ☐ Z83.42 Family history of familial hypercholesterolemia
- ☐ Other ______

Additional information ***Please attach a copy of the patient's most recent lipids and LFTs***

Weight ______ ☐ lb ☐ kg **Height** ______ ☐ in
Allergies ______

LDL-C ______ mg/ml **Date** ______ **on which medication(s)** ______
Describe history of atherosclerotic cardiovascular disease (ASCVD or FH) ______
Other pertinent medical history or drug therapy ______

Prior lipid-lowering treatment

Drug	Dose (mg)	Start Date	End Date	Reason for Discontinuation
______	______	______	______ or ☐ Current Med.	______
______	______	______	______ or ☐ Current Med.	______
______	______	______	______ or ☐ Current Med.	______
______	______	______	______ or ☐ Current Med.	______

Medication	Directions	Quantity	Type	Refills
☐ **Praluent®** (alirocumab)	☐ Inject 75mg SQ every 2 weeks. ☐ Inject 300mg (two-150mg injections) SQ every 4 weeks. ☐ Inject 150mg SQ every 2 weeks.	☐ 2 x 75mg/mL ☐ 2 x 150mg/mL ☐ 2 x 150mg/mL	☐ Pen ☐ Syringe	______
☐ **Repatha®** (evolocumab)	☐ Inject 140mg SQ every 2 weeks. ☐ Inject 420mg SQ every 4 weeks. ☐ Administer 420mg SQ once monthly using the on-body infuser with prefilled cartridge.	☐ 2 x 140 mg/mL ☐ 3 x 140 mg/mL ☐ 1 x 420mg/3.5mL	☐ Sureclick® ☐ Syringe Pushtronex® system	______
☐ Other Medication Drug ______	☐ ______	☐ ______	☐ ______	______

Please note: To increase adherence and patient acceptance all medications will be dispensed as pen type injectors unless unavailable or otherwise specified.

Provider Signature ______ **Date** ______

My signature for this prescription confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies if necessary, in conjunction with the therapy prescribed above.

V121919A

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