Hypercholesterolemia Referral Form

Referral for Medication and Patient Management Program

Phone: 877 385 0535 Fax: 877 326 2856

OptiMed SPECIALTY PHARMACY

V.05.22.17.A

With this referral, please fax a copy (front and back) of the patient's insurance card as well as copies of any relevant clinical notes, documents, and laboratory results.

Patient Demographics

Name: _____ ☐M ☐F
DOB: _____ SS#: _____
Phone: _____ 2nd Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary language, if other than English: _____
Patient weight: _____ Patient height: _____
Allergies: _____
_____

Prescriber Information

Prescriber: _____
_____
Phone: _____ Fax: _____
Address: _____
_____
NPI: _____ Office contact: _____
This is a: ☐New Rx ☐Refill
Training by: ☐Prescriber ☐Pharmacy to facilitate ☐Not needed
Deliver 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)*:

- ☐ E78.00 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: _____

Prior lipid-lowering treatment:

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

Additional Information:

LDL-C: _____ **Date:** _____ **On which medication(s):** _____
Describe history of atherosclerotic cardiovascular disease (ASCVD or FH): _____
_____
Other pertinent medical history or drug therapy: _____

Prescription Information

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

Provider Signature: _____ **Date:** _____

My signature confirms that the treatment(s) indicated on this referral is/are medically necessary, and 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/or to assist in obtaining patient financial assistance for this prescription and for all future fills of the same prescription.