REPATHA & PRALUENT REFERRAL FORM

BARNERT PHARMACY
"FAST, FRIENDLY, DEPENDABLE SERVICE"

680 Broadway Suite 108
Paterson, NJ 07514

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Patient Information

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB_____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address_____ Apt#_____ City_____ State_____ Zip_____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address
Allergies_____
Current Medications including OTC's (*please fax a complete list*)_____

Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____

Primary Insurance _____
ID# _____ Group#_____
Secondary Insurance _____
ID# _____ Group#_____

Ordering Prescriber

Office Contact _____
Street Address _____ Suite #_____
City _____ State_____ Zip_____
Tel _____ Fax _____
Email _____
License#_____
NPI# _____

ICD-10 Code
☐ **E78.0** HoFH Pure Hypercholesterolemia
☐ **E78.01** HeFH Pure Hypercholesterolemia
☐ **E78.2** Mixed Hyperlipidemia
☐ **E78.4** Other Hyperlipidemia
☐ **E78.5** Hyperlipidemia, unspecified
☐Other _____

Please add one secondary ICD-10-CM code:_____ Date of Diagnosis_____
Blood Pressure_____ Current smoker? ☐ Yes ☐ No
LDL-C Value_____ mg/dL on date_____

☐**Yes** ☐ **No** Will patient continue to receive comprehensive counselling regarding appropriate diet?
☐**Yes** ☐ **No** Will patient continue to receive a low-fat diet and exercise regiment?
☐**Yes** ☐ **No** Will Repatha be used in combination w/ another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?
Please attached a copy of patient's most recent lipid panel

PREVIOUS OR CURRENT LIPID LOWERING TREATMENTS

☐ none

	Strength/Freq	*Dates of Therapy*	*Contraindications*
Atorvastatin (Lipitor®)	_____mg/_____	mm/yy_____to_____	_____
Ezetimibe (Zetia®)	_____mg/_____	mm/yy_____to_____	_____
Pravastatin (Pravachol®)	_____mg/_____	mm/yy_____to_____	_____
Rosuvastatin (Crestor®)	_____mg/_____	mm/yy_____to_____	_____
Simvastatin (Zocor®)	_____mg/_____	mm/yy_____to_____	_____
Pitavastsatin (Livalo®)	_____mg/_____	mm/yy_____to_____	_____
Ezetimibe/ Simvastatin (Vytorin®)	_____mg/_____	mm/yy_____to_____	_____
Other _____	_____mg/_____	mm/yy_____to_____	_____
Other _____	_____mg/_____	mm/yy_____to_____	_____

Prescription

☐ **PRALUENT® (alirocumab)** ☐ Pre-filled **Pen** 2-Pack ☐ Pre-filled **Syringe** 2-Pack ☐ 75 mg/mL ☐150 mg/mL
SIG: Inject ☐ 75 mg **OR** ☐ 150 mg every 2 weeks
SIG: Inject ☐ 300 mg subcutaneously every 4 weeks
(to administer a 300 mg dose, give two150mg injections consecutively at two different injection sites)
QTY: ☐ 1 month supply ☐ 3 month supply Other_____ Refills: _____

☐ **REPATHA® (evolocumab)** ☐ 140mg/ml single-use prefilled SureClick® **autoinjector** ☐ 140mg/ml Pre-filled **Syringe**
☐ 420mg/3.5mL single-use prefilled Pushtronex **on-body infusor**
SIG: ☐ Inject 140 mg subcutaneously every 2 weeks
SIG: ☐ Inject 420 mg subcutaneously once a month **(for E78.01 only)**
QTY: ☐ 1 month supply ☐ 3 month supply ☐ Other_____ Refills: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

By signing this form I authorize Barnert Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

_____ **Prescriber's signature** (no stamps) if brand required check this ☐ DAW____ **Date**_____