# CARDIOVASCULAR

Lake Mary, FL toll free 855.733.3126 toll free fax 888.315.3270
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

## PATIENT INFO

Patient Name

Address

City, State, Zip

Main Phone Alternate Phone

Social Security #

Date of Birth ❑ Male ❑ Female

## PRESCRIBER INFO

Prescriber Name

DEA # NPI # License #

Address

City, State, Zip

Phone Fax

Contact Person

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

**Diagnosis:** ❑ E78.00 Pure Hypercholesterolemia (including HeFH and HoFH) ❑ E78.01 Familial Hypercholesterolemia ❑ E78.2 Mixed Hyperlipidemia ❑ E78.4 Other Hyperlipidemia ❑ E78.5 Unspecified Hyperlipidemia ❑ ASCVD Specifc Code(s) _____

**Drug Allergies:** _____

**Please provide one secondary ICD-10-CM code:** ❑ I20.0 Unstable Angina ❑ I20.9 Angina Pectoris, Unspecified ❑ I21.___ Acute Myocardial Infarction ❑ I22._____ Subsequent Myocardial Infarction ❑ I25._____ Chronic Ischemic Heart Disease ❑ I63._____ Cerebral Infarction ❑ I65._____ Occlusion and Stenosis of Cerebral Arteries, Extracranial ❑ I66._____ Occlusion and Stenosis of Cerebral Arteries, Intracranial ❑ I67._____ Other Cerebrovascular Diseases ❑ I70._____Atherosclerosis ❑ I73.9 Peripheral Vascular Disease, Unspecified ❑ G45.9 Transient Cerebral Ischemic Attack, Unspecified ❑ G46._____ Vascular Syndromes ❑ Other (specify ICD-10-CM): _____

Most recent LDL-C level on treatment _____ Date _____

Prior and/or Current Treatments: ❑ Atorvastatin (Lipitor®) ❑ Ezetimibe (Zetia®) ❑ Pravastatin (Pravachol®) ❑ Rosuvastatin (Crestor®) ❑ Simvastatin (Zocor®)

Other _____

Dose _____ Length of Treatment _____ Reason for Discontinuing _____

Family History of ACSVD_____Yes_____No Allergies_____ Does patient have a latex allergy? ❑ Yes ❑ No

| PRESCRIPTION INFORMATION | | | QUANTITY | REFILLS |
|---|---|---|---|---|
| Praluent™ | ❑ 75 mg/mL Prefilled Pen 2 pack<br>❑ 150 mg/mL Prefilled Pen 2 pack | Inject subcutaneously once every 2 weeks | 4 week supply | _____ |
| | ❑ 150 mg/mL Prefilled Pen 2 pack | Inject 300mg (2-150mg) subcutaneously once every 4 weeks | | |
| Repatha™ | ❑ 140 mg/mL SureClick® 2 pack | Inject subcutaneously once every 2 weeks | 4 week supply | _____ |
| | ❑ 420 mg/3.5 mL single-use Pushtronex™ System | Administer subcutaneously once monthly over 9 minutes by using the single-use on-body infusor with prefilled cartridge | | |

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date

Prescriber's Signature (no stamps) Dispense As Written Date