



SPECIALTY PHARMACY

CARDIOVASCULAR

Garden Grove, CA toll free 800.228.3643 toll free fax 866.539.1092

krogerspecialtypharmacy.com

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

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Person	

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

CLINICAL INFORMATION

Diagnosis: ☐ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH) ☐ E78.2 Mixed Hyperlipidemia ☐ E78.4 Other Hyperlipidemia
☐ E78.5 Unspecified Hyperlipidemia ☐ ASCVD Specific 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™	<input type="checkbox"/> 75 mg/mL Pre filled Pen 2 pack <input type="checkbox"/> 150 mg/mL Pre filled Pen 2 pack <input type="checkbox"/> 75 mg/mL Pre filled Syringe 2 pack	<input type="checkbox"/> Inject subcutaneously once every 2 weeks	4 week supply	_____
Repatha™	<input type="checkbox"/> 140 mg/mL SureClick® 2 pack <input type="checkbox"/> 140 mg/mL Pre filled Syringe 1 pack	<input type="checkbox"/> Inject subcutaneously once every 2 weeks <input type="checkbox"/> Inject subcutaneously monthly (3 injections to be given consecutively within 30 minutes)	4 week supply	_____
	<input type="checkbox"/> 420 mg/3.5 mL single-use Pushtronex™ System	<input type="checkbox"/> 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 its 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

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