



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: ☐ E78.00 Pure Hypercholesterolemia (including HeFH and HoFH) ☐ E78.01 Familial Hypercholesterolemia ☐ 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 Prefilled Pen 2 pack<br><input type="checkbox"/> 150 mg/mL Prefilled Pen 2 pack | Inject subcutaneously once every 2 weeks   | 4 week supply | _____   |
|                          | <input type="checkbox"/> 150 mg/mL Prefilled Pen 2 pack   | Inject 300mg (2-150mg) subcutaneously once every 4 weeks   |               |         |
| Repatha™                 | <input type="checkbox"/> 140 mg/mL SureClick® 2 pack  | Inject subcutaneously once every 2 weeks   | 4 week supply | _____   |
|                          | <input type="checkbox"/> 420 mg/3.5 mL single-use<br>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 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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