HYPERCHOLESTEROLEMIA REFERRAL FORM

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24/7 Emergency Hotline: 866-989-0900
www.nymannings.com specialty@nymannings.com

Today's Date **Anticipated Start Date**

NEW PATIENT **CURRENT PATIENT**

PATIENT INFORMATION:

Patient Name ______________________ DOB__________ Weight__________ Male Female
Street Address______________________ Apt#________ City______________ State________ Zip________
Daytime Tel______________ Even Tel______________ Cell______________ Email______________
Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed______________

Insured's Name______________ Relation to Patient__________ Eligible for Medicare Yes No If yes, Medicare#__________
Prescription Card Yes No If Yes, Carrier______________ Tel______________ Fax______________ Policy/Group#__________
Bin#______________ Pcn#______________ RX Group#______________ RXID#______________

PRESCRIBING PHYSICIAN INFORMATION:

Prescriber's Name______________________ Office Contact______________________
Street Address______________________ Suite#________ City______________ State________ Zip________
Tel______________ Fax______________ Email______________________
License#______________ NPI#______________ UPIN#______________ DEA#______________

CLINICAL INFORMATION:

Diagnosis: E78.00 (Pure hypercholesterolemia, unspecified) E78.01 (Familial hypercholesterolemia - Homozygous Heterozygous)
E78.2 (Mixed hyperlipidemia) E78.4 (Other hyperlipidemia) E78.5 (Hyperlipidemia, Unspecified)

For ASCVD patients, MUST select appropriate code for Hypercholesterolemia AND ASVCD

Clinical ASCVD-specific code(s): ______________ ______________
Lab Results: LDL-C ______________mg/dl **Result Date:** ______________

Prior Therapy: Yes No	**Reason for Discontinuation of Therapy:**	**Approximate State Date**	**Approximate End Date**
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________

Comorbidities:______________________
Concomitant Medications:______________________
Allergies: NKDA Other:______________________

PRESCRIPTION PLEASE E-SCRIBE & ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Medication	Directions	Quantity		Refills
Praluent® (alirocumab)	Inject 75 mg subcut every 2 weeks Inject 150 mg subcut every 2 weeks	2 x 75 mg/mL 2 x 150 mg/mL	PFS Pen	
Repatha® (evolocumab)	Inject 140 mg subcut every 2 weeks	2 x 140 mg/mL	PFS	
	Administer 420 mg subcut via on-body infusor over 9 minutes	1 x 420 mg/3.5 mL	Pushtronex™	

Injection Training Provided by: Prescriber's Office Manuf. provided Nurse

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless noted otherwise: ______________________

PRESCRIBER SIGNATURE: (signature required. NO STAMPS) **DATE:**

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