



STAR CARE PHARMACY

"The First Wealth is Health"

175-20 Hillside Avenue • Jamaica, NY 11432

Tel: 718-262-8789 • Fax: 718-262-9083

Toll Free: 888-216-STAR (7827)

CARDIOLOGY REFERRAL FORM

Date: _____ Attn: _____

Ship to Patient Physician Office Nurse/Training

Patient Name _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Home Tel _____ Work Tel _____
 Cell _____ Email _____
 Date of Birth _____ SS# _____
 Male Female Weight _____ Height _____

Prescriber's Name _____
 License# _____ DEA# _____
 NPI# _____ UPIN# _____
 Practice Name _____
 Office Contact _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____

Insurance Information (Complete or attach copies of cards)

Primary Insurance: _____ Insured's Name: _____
 ID#: _____ City: _____ State: _____ Phone: () _____ - _____
 Group #: _____ Employer: _____

Diagnostic & Clinical Information

ICD-10 Diagnosis: E78.0 Pure hypercholesterolemia E78.2 Mixed hyperlipidemia E78.4 Other hyperlipidemia
 E78.5 Hyperlipidemia, unspecified Weight _____ Blood Pressure _____
 Current smoker? Yes No LDL-C Value _____ mg/dL on date _____
 Current medications patient (including OTC) with dosage and direction (or fax medication) _____

Prescription

PREVIOUS OR CURRENT LIPID LOWERING TREATMENTS

none

	<u>Strength/Freq</u>	<u>Dates of Therapy</u>
<input type="checkbox"/> Atorvastatin (Lipitor®)	_____ mg/ _____	mm/yy _____ to _____
<input type="checkbox"/> Ezetimibe (Zetia®)	_____ mg/ _____	mm/yy _____ to _____
<input type="checkbox"/> Pravastatin (Pravachol®)	_____ mg/ _____	mm/yy _____ to _____
<input type="checkbox"/> Rosuvastatin (Crestor®)	_____ mg/ _____	mm/yy _____ to _____
<input type="checkbox"/> Simvastatin (Zocor®)	_____ mg/ _____	mm/yy _____ to _____
<input type="checkbox"/> Other _____	_____ mg/ _____	mm/yy _____ to _____
<input type="checkbox"/> Other _____	_____ mg/ _____	mm/yy _____ to _____

REPATHA® (evolocumab)

140 mg/ml single-use prefilled SureClick® autoinjector

SIG: Inject 140 mg subcutaneously every 2 weeks

QTY: 1 month supply 3 month supply Other _____ Refills _____

PRALUENT® (alirocumab)

Pre-filled Pen 2-Pack Pre-filled Syringe 2-Pack

75 mg/mL 150 mg/mL

SIG: Inject 1 mL subcutaneously every 2 weeks

QTY: 1 month supply 3 month supply Other _____ Refills _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.