STAR CARE PHARMACY

"The First Wealth is Health"

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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: _____
ID#: _____
Group #: _____

Insured's Name: _____
City: _____ State: _____ Phone: ( ) _____ - _____
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

	Strength/Freq	Dates of Therapy
☐ Atorvastatin (Lipitor®)	_____mg/ _____	mm/yy _____ to _____
☐ Ezetimibe (Zetia®)	_____mg/ _____	mm/yy _____ to _____
☐ Pravastatin (Pravachol®)	_____mg/ _____	mm/yy _____ to _____
☐ Rosuvastatin (Crestor®)	_____mg/ _____	mm/yy _____ to _____
☐ Simvastatin (Zocor®)	_____mg/ _____	mm/yy _____ to _____
☐ Other_____	_____mg/ _____	mm/yy _____ to _____
☐ 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** _____