HYPERCHOLESTEROLEMIA HEALTH REFERRAL FORM

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Patient Information

Patient Name: ______________________ DOB: ______________ Sex: ☐ M ☐ F

Phone: ______________ Cell Phone: ______________ Email Address: ______________

Address: ______________________ City: ______________ State: ______ Zip: __________

ICD-10 Diagnosis Code: ______________ Diagnosis: ______________________

Allergies (please note reaction): ______________________ ☐ Latex

Current Medications: (list here or attach a medication list): ______________________

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Comorbidities: (list here or attach a list): ______________________

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Praluent (alirocumab)	☐ 75mg/mL Prefilled Syringe	☐ Inject 75mg subcutaneously every 2 weeks.	28-day supply	
	☐ 75mg/mL Pen Injector	☐ Inject 150mg subcutaneously every 2 weeks.		
	☐ 150mg/mL Prefilled Syringe	☐ Inject 300mg subcutaneously every 4 weeks.		
	☐ 150mg/mL Pen Injector			
☐ Repatha (evolocumab)	☐ 140mg/mL Prefilled Syringe	☐ Inject 140mg subcutaneously every 2 weeks	28-day supply	
	☐ 140mg/mL Auto-injector	☐ Inject 420mg subcutaneously once monthly.		
	☐ 420mg/3.5mL Pushtronex (On-body infusor with prefilled cartridge)	☐ Inject 420mg subcutaneously once monthly.		
Other Medication Name:				

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Prescriber Information

Prescriber Name: ____

State License #: ______________ DEA #: ______________ NPI: ______________

Additional Contact Person Name: ____

Group or Hospital: ______________________ Phone: ______________

Fax: ______________ Email Address: ______________________

Address: ______________________ City: ______________ State: ______ Zip: __________

Prescriber Signature: ______________________ ______________________ __________

Product Substitution Permitted — Dispensed as Written — Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy

Date Medication Needed: ______________________

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