Pharmacy Hy-Vee SOLUTIONS

Cardiology Referral Form

Please complete the form and fax to: **855.861.4941**

877.RxHyVee (877.794.9833)
10004 S. 152nd Street, Suite C
Omaha, NE 68138

Patient Information *Please Fax a Copy of Patient's Insurance Card (Front and Back)*

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Gender (M/F)	Date of Birth	Primary Caregiver Name and Phone	Emergency Contact Name and Phone

Clinical Assessment *Please FAX recent clinical notes, labs, tests, with the prescription to expedite the Prior Authorization process*

Diagnosis

ICD-10 Code:

❑ **E38.0** (Pure Hypercholesterolemia) ❑ **E38.2** (Mixed Hyperlipidemia) ❑ **E38.4** (Other Hyperlipidemia) ❑ **E38.5** (Unspecified Hyperlipidemia)

Type of Familial Hypercholesterolemia: ❑ HeFH (Heterozygous) ❑ HoFH (Homozygous)

ASCVD-Specific Code (ICD-9/ICD-10): _____

For clinical ASCVD patients, please select the appropriate ICD code for hypercholesterolemia AND include the specific ASCVD diagnosis code.

Previous Lipid-Lowering Treatments: ❑ None ❑ Yes (Check all that apply)

	Strength/Freq	Dates of Therapy
❑ atorvastatin	____mg/ ____	mm/yy _____ to _____
❑ ezetimibe	____mg/ ____	mm/yy _____ to _____
❑ pravastatin	____mg/ ____	mm/yy _____ to _____
❑ rosuvastatin	____mg/ ____	mm/yy _____ to _____
❑ simvastatin	____mg/ ____	mm/yy _____ to _____
❑ Other: _____	____mg/ ____	mm/yy _____ to _____

Other Lipid-Lowering Agents to be Used Concurrently with PCSK9 Treatment:

❑ None ❑ Yes (Please indicate below):

_____

_____

_____

Is the patient statin intolerant? ❑ Yes ❑ No If Yes, describe intolerance: _____

Any other contraindications to non-PCSK9 therapy for hypercholesterolemia? _____

Lab Values: ❑ LDL-C _____ mg/dL Date: _____ **Drug Allergies:** _____

❑ Sharps container and alcohol pads to be provided as needed ❑ Injection training needed

Medication	Dose/Strength	Directions for Use	Quantity	Refills
❑ **Praluent®** ❑ Pre-filled **Pen**	❑ 75 mg/ml 2-count	❑ Inject 75 mg SQ every 2 weeks	28 days	
❑ **Repatha™** Pre-Filled **Syringe**	❑ 140 mg/ml 1-Pack (Syringe)	❑ Inject 140 mg SQ every 2 weeks (2 Syringes)	28 days	
❑ **Repatha™ SureClick® Autoinjector**	❑ 140 mg/ml 2-Pack (Pen)	❑ Inject 420 mg SQ once monthly (3 Syringes) ❑ Inject 140 mg SQ every 2 week	One month 28 days	

Prescriber/Shipping Information **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Nurse/Key Contact	Phone or Pager Number	Email

Date Shipment Needed:	Ship to: ❑ Patient ❑ Physician/Clinic ❑ Other/Special Instructions:	Nurse Training Needed? ❑ Yes ❑ No

Physician Signature: _____ ❑ **DAW** (Dispense as Written) **Date:** ____/____/____