aleracare
advanced specialty pharmacy

Cardiology
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Considerations

ICD-10 Codes:
- ◯ E78.0 (Pure Hypercholesterolemia)
- ◯ E78.2 (Mixed hyperlipidemia)
- ◯ E78.4 (Other Hyperlipidemia)
- ◯ E78.5 (Unspecified Hyperlipidemia)

ASCVD-Specific 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:** _____

Medication	Dose	Directions for Use	Qty	Refills
◯ **REPATHA®** (evolocumab) ◯ Prefilled Syringe ◯ Prefilled SureClick Auto-Injector	◯ 140mg/ml	◯ Inject 140mg SQ every 2 weeks ◯ Inject 420 mg SQ once a month		
◯ **PRALUENT®** (alirocumab) ◯ Prefilled Pen ◯ Prefilled Syringe	◯ 75mg/ml ◯ 150mg/ml	◯ Inject 140mg SQ every 2 weeks ◯ Inject 420 mg SQ once a month		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____