aleracare
advanced specialty pharmacy

Lipid-Lowering Injectables

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:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (ID & Group #) ◯ Current Medications ◯ History/Progress Notes

Labs Needed Prior to Initiation

◯ Lipid Profile

Diagnosis

ICD-10 Codes: ◯ Primary Hyperlipidemia ◯ E78.01 Familial Hypercholesterolemia Other:_____

Medication	Dose	Directions for Use	Qty	Refills
◯ **REPATHA®** (evolocumab) ◯ **PFS** ◯ **Sureclick**	◯ 140 mg/mL	◯ Inject 140 mg subq every 2 weeks	2	
◯ **REPATHA PUSHTRONEX®** (evolocumab)	◯ 420 mg/3.5 mL	◯ Inject 420 mg subq every month	1	
◯ **PRALUENT® Pen** (alirocumab)	◯ 75 mg/mL ◯ 150 mg/mL	◯ Inject 75 mg subq every 2 weeks ◯ Inject 150 mg subq every 2 weeks ◯ Inject 300 mg subq every 4 weeks Other: _____	2 2 2	
◯ **LEQVIO® PFS** (inclisiran)	◯ 284 mg/1.5 mL	◯ Inject 284 mg subq x 1 dose ◯ Then: Inject 284 mg subq at month 3 ◯ Then: Inject 284 mg subq every 6 months	1 1 1	

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** _____