



RICHMOND PHARMACY

Specialty Script

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HYPERCHOLESTEROLEMIA REFERRAL FORM

Date: ____/____/____ Needs by Date: _____

Language: _____ Nursing Instruction Required

Ship to: Patient MD Office

Prescriber's Name: _____ DEA #: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: ____/____/____ Gender: F M

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION

ICD-10 Codes and Diagnosis

Primary ICD-10 (must select one)

- E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)
- E78.2 Mixed Hyperlipidemia
- E78.4 Other Hyperlipidemia
- E78.5 Hyperlipidemia, unspecified

Secondary ICD-10 (select all that apply)

- 120.0 Unstable Angina
- 120.9 Angina Pectoris
- 121. ___ Acute Myocardial Infarction
- 122. ___ Subsequent Myocardial Infarction
- 125. ___ Chronic Ischemic Heart Disease
- 163. ___ Cerebral Infarction
- 165. ___ Occlusion and stenosis of Cerebral Arteries, Intracranial
- 167. ___ Other Cerebrovascular Diseases
- Other, Specify ICD-10 _____

Previous Treatment (select all that apply)

- | | | | | | |
|------------------------|------|------|------|------|------|
| Atorvastatin (Lipitor) | 10mg | 20mg | 40mg | 80mg | |
| Rosuvastatin (Crestor) | 5mg | 10mg | 20mg | 40mg | |
| Simvastatin (Zocor) | 5mg | 10mg | 20mg | 40mg | 80mg |
| Ezetimibe (Zetia) | 10mg | | | | |

Other statin/lipid lowering agent(s): _____

Current therapy: _____ Dose: _____ Date Started: _____

Achieved maximum tolerated statin dose?

Lab Results:

please attach a copy of patients most recent lipid panel

LDL-C _____ mg/ml Date _____

Intolerance to statins (list medications and dose failed): _____

Rhabdomyolysis Myositis Myalgia

Baseline LFT's: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QTY.	REFILLS
Praluent *	75 mg/mL Pen 75 mg/mL PFS 150 mg/mL Pen 150 mg/mL PFS	Inject subcutaneously every 2 weeks Other: _____	1 month supply Other: _____	
Repatha "	140 mg/mL PFS 140 mg/mL SureClick®	Inject 140 mg sub-Q every 2 weeks Inject 420 mg sub-Q every 4 weeks	1 pack = 1 x 140 mg/mL PFS 1 pack = 1 x 140 mg/mL SureClick® 2 pack = 2 x 140 mg/mL SureClick® 3 pack = 3 x 140 mg/mL SureClick®	

Physician Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

*For additional information please visit our website www.RichmondSpecialty.com
ePrescribe to our pharmacy "Richmond Pharmacy Specialty" • (718) 818-2178*