SPECIALTY PHARMACY

CARDIOVASCULAR

Lake Mary, FL toll free toll free fax
krogerspecialtypharmacy.com

DATE: _______________ NEEDS BY DATE: _______________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _______________

PATIENT INFO		PRESCRIBER INFO		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License #
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #		Phone	Fax	
Date of Birth	❑ Male ❑ Female	Contact Person		

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑ E78.00 Pure Hypercholesterolemia (including HeFH and HoFH) ❑ E78.01 Familial Hypercholesterolemia ❑ E78.2 Mixed Hyperlipidemia ❑ E78.4 Other Hyperlipidemia ❑ E78.5 Unspecified Hyperlipidemia ❑ ASCVD Specifc Code(s) _______________

Drug Allergies: _______________

Please provide one secondary ICD-10-CM code: ❑ I20.0 Unstable Angina ❑ I20.9 Angina Pectoris, Unspecified ❑ I21.____ Acute Myocardial Infarction
❑ I22._______ Subsequent Myocardial Infarction ❑ I25._______ Chronic Ischemic Heart Disease ❑ I63.______ Cerebral Infarction
❑ I65._______ Occlusion and Stenosis of Cerebral Arteries, Extracranial ❑ I66.______ Occlusion and Stenosis of Cerebral Arteries, Intracranial
❑ I67.______ Other Cerebrovascular Diseases ❑ I70.________Atherosclerosis ❑ I73.9 Peripheral Vascular Disease, Unspecified
❑ G45.9 Transient Cerebral Ischemic Attack, Unspecified ❑ G46.______ Vascular Syndromes ❑ Other (specify ICD-10-CM): _______________

Most recent LDL-C level on treatment _______________ Date ____________

Prior and/or Current Treatments: ❑ Atorvastatin (Lipitor®) ❑ Ezetimibe (Zetia®) ❑ Pravastatin (Pravachol®) ❑ Rosuvastatin (Crestor®) ❑ Simvastatin (Zocor®)

Other _______________

Dose _______________ Length of Treatment _______________ Reason for Discontinuing _______________

Family History of ASCVD______Yes______No Allergies_______________ Does patient have a latex allergy? ❑ Yes ❑ No

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
Praluent™	❑ 75 mg/mL Prefilled Pen 2 pack ❑ 150 mg/mL Prefilled Pen 2 pack	Inject subcutaneously once every 2 weeks	4 week supply	_________
	❑ 150 mg/mL Prefilled Pen 2 pack	Inject 300mg (2-150mg) subcutaneously once every 4 weeks		
Repatha™	❑ 140 mg/mL SureClick® 2 pack	Inject subcutaneously once every 2 weeks	4 week supply	_________
	❑ 420 mg/3.5 mL single-use Pushtronex™ System	Administer subcutaneously once monthly over 9 minutes by using the single-use on-body infusor with prefilled cartridge		

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted ____________ Date ____________ Prescriber's Signature (no stamps) Dispense As Written ____________ Date ____________

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