PRALUENT & REPATHA REFERRAL FORM

V-Care Pharmacy
Specialty + Medical & Surgical Supplies
151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 844.7.MYVCARE | Fx 508.202.9343 | Fx 844.230.6211

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

JULY 2016

Patient Name First Name Last Name SS# DOB Height Weight ☐ Male ☐ Female
Street Address Apt # City State Zip
Daytime Tel Evening Tel Cell Email
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed
Allergies Comorbidities
Current Medications (if necessary, please fax a complete list)

ICD-10 Diagnosis: ☐ E78.0 Pure hypercholesterolemia ☐ E78.2 Mixed hyperlipidemia ☐ E78.4 Other hyperlipidemia ☐ E78.5 Hyperlipidemia, unspecified
Weight Blood Pressure Current smoker? ☐ Yes ☐ No

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#
Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#
Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact
Street Address Suite # City State Zip
Tel Fax Email
License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PREVIOUS OR CURRENT LIPID LOWERING TREATMENTS

☐ none

	Strength/Freq	*Dates of Therapy*
☐ Atorvastatin (Lipitor®)	_____mg/ _____	mm/yy _____ to _____
☐ Ezetimibe (Zetia®)	_____mg/ _____	mm/yy _____ to _____
☐ Pravastatin (Pravachol®)	_____mg/ _____	mm/yy _____ to _____
☐ Rosuvastatin (Crestor®)	_____mg/ _____	mm/yy _____ to _____
☐ Simvastatin (Zocor®)	_____mg/ _____	mm/yy _____ to _____
☐ Other_____	_____mg/ _____	mm/yy _____ to _____
☐ Other_____	_____mg/ _____	mm/yy _____ to _____

Achieved maximum tolerated statin dose? ☐ Yes ☐ No

PRALUENT® (alirocumab)

☐ Pre-filled **Pen** 2-Pack ☐ Pre-filled **Syringe** 2-Pack
☐ 75 mg/mL ☐ 150 mg/mL
SIG: Inject 1 mL subcutaneously every 2 weeks
QTY: ☐ 1 month supply ☐ 3 month supply ☐ Other _____ Refills

REPATHA® (evolocumab)

☐ 140 mg/ml single-use prefilled SureClick® autoinjector
SIG: Inject 140 mg subcutaneously every 2 weeks
QTY: ☐ 1 month supply ☐ 3 month supply ☐ Other _____ Refills

By signing this form and utilizing our services, you are authorizing V-Care Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

CLINICAL INFORMATION

[PRALUENT & REPATHA] Please indicate the following for any requests:
Total cholesterol level_____ Date taken_____ **AND** LDL Level_____ Date taken_____ On statin therapy when tests were taken? ☐ Yes ☐ No
☐ Yes ☐ No Does patient have severe renal impairment? (eGFR < 30ml/min)
☐ Yes ☐ No Does patient have severe hepatic impairment?
☐ Yes ☐ No ☐ N/A If female, is patient pregnant or plan to become pregnant?

[PRALUENT & REPATHA] For initial requests:
☐ Yes ☐ No Has patient failed therapy with 2 different max-tolerated doses of high-potency statins, used in combination with Zetia (ezetimibe)?
*(if maximum statin doses weren't used, please indicate reason for using lower dose*_____)
If yes: Indicate date range of Zetia (ezetimibe) therapy_____
Please also indicate regimen #1: Medication Name:_____ Dose:_____ Duration:_____ State Date:_____
LDL level after 4 weeks of treatment:_____ Date taken:_____
☐ Yes ☐ No Was patient at least 80% compliant with treatment? If no, explain:_____
Please also indicate regimen #2: Medication Name:_____ Dose:_____ Duration:_____ State Date:_____
LDL level after 4 weeks of treatment:_____ Date taken:_____
☐ Yes ☐ No Was patient at least 80% compliant with treatment? If no, explain:_____
☐ Yes ☐ No Will patient be taking ☐ ***Repatha*** **OR** ☐ ***Praluent*** in combination with a statin?
☐ Yes ☐ No Has patient been diagnosed with ***Heterozygous familial hypercholesterolemia (HeFH)***?
If yes: ☐ Yes ☐ No Was LDL-cholesterol level higher than 190 mg/dl either pretreatment or highest at time of treatment?
☐ Yes ☐ No Does patient have documentation of tendon xanthomas?
☐ Yes ☐ No If answer is "no" to the 2 above questions, is there evidence of these signs in a first or second-degree relative?
☐ Yes ☐ No Is there clinical documentation of DNA based evidence of a receptor mutation, such as LDL-R, apo-B100, or PCSK9 mutation?
☐ Yes ☐ No Is there clinical documentation of other genetic typing indicating presence of ***Heterozygous familial hypercholesterolemia (HeFH)?***
☐ Yes ☐ No Does patient have an ***existing clinical cardiovascular disease***?
If yes: ☐ Yes ☐ No Does patient have existsing cardiovascular disease as evidenced by a history of AMi, silent MI, unstable angina or a coronary revascularization procedure? ***If yes indicate which of the following pertains to patient:***
☐ acute myocardial infarction ☐ silent myocardial infarction ☐ unstable angina ☐ coronary revascularization procedure (CABG or PCI)
☐ Yes ☐ No Does patient have clinically significant artherosclerotic cardiovascular disease diagnosed by invasive or non-invasive testing, such as coronary angiography, stress testing using treadmill, stress echocardiography, or nuclear imaging?
[FOR REPATHA ONLY] ☐ Yes ☐ No Is there genetic confirmation of a diagnosis with ***Homozygous familial hypercholesterolemia (HoFH)***?
If yes: Indicate what type of genetic testing was performed to obtain diagnosis_____
☐ Yes ☐ No Will patient be taking Repatha in combination with a statin or other lipid lowering therapy?
☐ Yes ☐ No Did patient have the presence of xanthomas before the age of 10?
☐ Yes ☐ No Is there clinical evidence of Heterozygous familial hypercholesterolemia (HeFH) in **both** parents?

[PRALUENT & REPATHA] For continuation requests:
Patient's baseline LDL level_____ Date taken_____
☐ Yes ☐ No Was a reduction in LDL observed compared to baseline?
☐ Yes ☐ No Is continuation request resulting from samples of ☐ ***Repatha*** **OR** ☐ ***Praluent***? *(does not guaruntee coverage)*

[REPATHA] For HoFH patients:
☐ Yes ☐ No Is there clinical evidence of ongoing concomitant lipid lowering therapy?
If yes: Provide the name of lipid lowering therapy being taken:_____

[REPATHA] For HeFH or Artherosclerotic cardiovascular disease patients:
☐ Yes ☐ No Is there clinical evidence of ongoing concomitant statin use?
If yes: Provide the name of lipid lowering therapy being taken:_____