Pharmacy SOLUTIONS

Cardiology Referral Form

Please complete the form and fax to: **855.861.4941**

877.RxHyVee (877.794.9833)
10004 S. 152nd Street, Suite C
Omaha, NE 68138

Patient Information *Please Fax a Copy of Patient's Insurance Card (Front and Back)*

Last Name	First Name	Home Phone	Work/Mobile Phone

Home Address	City	State	ZIP

Shipping Address (if different from above)	City	State	ZIP

Social Security Number	Gender (M/F)	Date of Birth	Primary Caregiver Name and Phone	Emergency Contact Name and Phone

Clinical Assessment *Please FAX recent clinical notes, labs, tests, with the prescription to expedite the Prior Authorization process*

Diagnosis

ICD-9 Codes: ❑ **272.0** (Pure Hypercholesterolemia) ❑ **272.2** (Mixed Hyperlipidemia) ❑ **272.4** (Other Hyperlipidemia)

ICD-10 Codes: (When implemented, use ICD-10 codes)

❑ **E78.0** (Pure Hypercholesterolemia) ❑ **E78.2** (Mixed Hyperlipidemia) ❑ **E78.4** (Other Hyperlipidemia) ❑ **E78.5** (Unspecified Hyperlipidemia)

ASCVD-Specific Code (ICD-9/ICD-10): _____

For clinical ASCVD patients, please select the appropriate ICD code for hypercholesterolemia AND include the specific ASCVD diagnosis 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: _____ **Drug Allergies:** _____

❑ Sharps container and alcohol pads to be provided as needed ❑ Injection training needed

Medication	Dose/Strength	Directions for Use	Quantity	Refills
❑ **Praluent®** ❑ Pre-filled **Pen** ❑ Pre-filled **Syringe**	❑ 75 mg/ml 2-Pack ❑ 150 mg/ml 2-Pack	❑ Inject 75 mg SQ every 2 weeks ❑ Inject 150 mg SQ every 2 weeks	28 days	

Prescriber/Shipping Information **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI#*	Nurse/Key Contact	Phone or Pager Number	Email

Date Shipment Needed:	Ship to: ❑ Patient ❑ Physician/Clinic ❑ Other/Special Instructions:	Nurse Training Needed? ❑ Yes ❑ No

Physician Signature: _____ ❑ **DAW** (Dispense as Written) **Date:** ____/____/____

I authorize Hy-Vee Pharmacy Solutions and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.