MEMORIAL HERMANN Specialty Pharmacy

PCSK9 INHIBITOR REFERRAL FORM

Please sign and fax completed form to 713.704.3841
For questions, please call 281.698.6100

SHIP TO: ☐ Patient ☐ Office (1st dose) ☐ Office (All doses)

Patient Information

Please include copy of prescription and medical insurance card, front and back

Patient Name: _____ Date of Birth: _____
Street Address: _____ Phone: _____
City, State, Zip: _____ Allergies: _____

Prescriber Information

Prescriber Name: _____ NPI: _____
Specialty: _____ Phone: _____
Office Street Address: _____ Fax: _____
City, State, Zip: _____ Office Contact: [redacted]

Prescription Information

		Quantity	Form	Refills
☐ **Praluent** (alirocumab)	☐ Inject 75 mg subcutaneously every 2 weeks ☐ Inject 150 mg subcutaneously every 2 weeks ☐ Inject 300 mg subcutaneously every 4 weeks	☐ 2 x 75 mg/mL (28 days) ☐ 2 x 150 mg/mL (28 days) ☐ 6 x 75 mg/mL (84 days) ☐ 6 x 150 mg/mL (84 days)	☐ Pen	Refills: _____
☐ **Repatha** (evolocumab)	☐ Inject 140 mg subcutaneously every 2 weeks ☐ Inject 420 mg subcutaneously every 4 weeks ☐ Inject 420 mg subcutaneously once monthly	☐ 2 x 140 mg/mL (28 days) ☐ 3 x 140 mg/mL (28 days) ☐ 6 X 140 mg/mL (56 days) ☐ 6 x 140 mg/mL (84 days) ☐ 9 x 140 mg/mL (84 days)	☐ Auto Injector ☐ PFS	Refills: _____

Patient Medical Information

**Please include copies of any pertinent clinical notes and lab work **

Please provide at least one primary **and** one secondary established CVD ICD-10 code:

Primary Codes:	Secondary Codes:	
☐ E78.00 Pure Hypercholesterolemia	☐ I20.0 Unstable Angina	☐ I63.___ Cerebral Infarction
☐ E78.01 Familial Hypercholesterolemia	☐ I20.9 Angina Pectoris	☐ I70.___ Atherosclerosis
☐ E78.2 Mixed Hyperlipidemia	☐ I21.___ Acute Myocardial Infarction	☐ I73.9 Peripheral Vascular Disease
☐ E78.4 Other Hyperlipidemia	☐ I22.___ Subsequent Myocardial Infarction	☐ G45.9 Transient Cerebral Ischemic Attack
	☐ I25.___ Chronic Ischemic Heart Disease	☐ Other (Specify ICD-10):_____

History of ASCVD Event

☐ None	☐ Angina	☐ Peripheral Artery Disease	Date of Event (if applicable)
	☐ Coronary or Other Arterial Revascularization	☐ Stroke	
	☐ Myocardial Infarction	☐ Transient Ischemic Attack	_____
	☐ Percutaneous Transluminal Coronary Angioplasty	☐ Other (Specify)_____	

Previous and/or Current Lipid-Lowering Treatments

Select therapies tried and maximally tolerated dose achieved	Current Use	Est. Start Date	Est. End Date	Discontinue Reason (if stopped)
☐ atorvastatin (Lipitor) ☐ 10mg ☐ 20mg ☐ 40mg ☐ 80mg	☐	_____	_____	☐ Failed ☐ Intolerant/Contraindicated Explanation:_____
☐ rosuvastatin (Crestor) ☐ 5mg ☐ 10mg ☐ 20mg ☐ 40mg	☐	_____	_____	☐ Failed ☐ Intolerant/Contraindicated Explanation:_____
☐ simvastatin (Zocor) ☐ 5mg ☐ 10mg ☐ 20mg ☐ 40mg ☐ 80mg	☐	_____	_____	☐ Failed ☐ Intolerant/Contraindicated Explanation:_____
☐ ezetimibe (Zetia) ☐ 10mg	☐	_____	_____	☐ Failed ☐ Intolerant/Contraindicated Explanation:_____
☐ other:_____	☐	_____	_____	☐ Failed ☐ Intolerant/Contraindicated Explanation:_____
☐ other:_____	☐	_____	_____	☐ Failed ☐ Intolerant/Contraindicated Explanation:_____

LDL Lab Results

LDL _____mg/dL Date: _____ Lab drawn while: ☐ On statin therapy ☐ On PCSK9 inhibitor therapy ☐ On other lipid-lowering therapy ☐ Off therapy
LDL _____mg/dL Date: _____ Lab drawn while: ☐ On statin therapy ☐ On PCSK9 inhibitor therapy ☐ On other lipid-lowering therapy ☐ Off therapy
LDL _____mg/dL Date: _____ Lab drawn while: ☐ On statin therapy ☐ On PCSK9 inhibitor therapy ☐ On other lipid-lowering therapy ☐ Off therapy

Prescriber Signature (No Stamps Permitted)

By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies. To prohibit generic substitution write "brand necessary" or "brand medically necessary" on the face of the prescription in your own handwriting.

Prescriber's Signature : _____ Date: _____

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