HYPERCHOLESTEROLEMIA HEALTH REFERRAL FORM

Albertsons Companies Specialty Care | MEDCART SPECIALTY PHARMACY | Jewel Osco | Albertsons | SAFEWAY | VONS | ACME | shaw's | star market | PAVILIONS | CARRS | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Praluent (alirocumab)	☐ 75mg/mL Prefilled Syringe	☐ Inject 75mg subcutaneously every 2 weeks.	2 pens/syringes	
	☐ 75mg/mL Pen Injector			
	☐ 150mg/mL Prefilled Syringe	☐ Inject 150mg subcutaneously every 2 weeks. ☐ Inject 300mg subcutaneously every 4 weeks.		
	☐ 150mg/mL Pen Injector			
☐ Repatha (evolocumab)	☐ 140mg/mL Prefilled Syringe	☐ Inject 140mg subcutaneously every 2 weeks	☐ 2 auto-injectors/syringes	
	☐ 140mg/mL Auto-injector	☐ Inject 420mg subcutaneously once monthly.	☐ 1 auto-injector/syringe	
	☐ 420mg/3.5mL Pushtronex (On-body infusor with prefilled cartridge)	☐ Inject 420mg subcutaneously once monthly.	☐ 1 on-body infusor	
Other Medication Name:				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: _____