Pharmax SPECIALTY PHARMACY

HYPERCHOLESTEROLEMIA REFERRAL FORM

TEL 813.880.2500
FAX 813.880.2501
TOLL FREE 1.866.880.2507

PATIENT INFORMATION

Name:_____ Address:_____ _____ _____ Phone:_____

SSN:_____ DOB:_____ Sex:_____

Weight:_____ Height:_____ Allergies:_____ Ship to: ☐ Patient ☐ Clinic

INSURANCE

Prescription Card: _____ Name of Insurer:_____ ID#_____ BIN:_____ PCN:_____

Group:_____ (Please attach copies of insurance cards.)

DIAGNOSIS

☐ E78.0 Pure Hypercholesterolemia ☐ E78.2 Mixed Hyperlipidemia ☐ E78.4 Other Hyperlipidemia ☐ E78.5 Hyperlipidemia, Unspecified

Clinical ASCVD-Specific Codes: _____

Previous Therapy: _____ Start Date: _____ End Date: _____ Reason for DC: _____

Active Medication List: _____

Lab Results: _____

LDL-C: _____ mg/ml Result Date: _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refill
☐ Praluent (Alirocumab)	☐ 75 mg/ml PFS ☐ 75 mg/ml Pen ☐ 150 mg/ml PFS ☐ 150 mg/ml Pen	☐ Inject 75 mg SC every 2 weeks ☐ Inject 150 mg every 2 weeks	☐ 2 X 75 mg/ml ☐ 2 X 150 mg/ml	
☐ Repatha (Evolocumab)	☐ 140 mg/ml PFS ☐ 140 mg/ml sureclick ☐ 420 mg/3.5 ml pushtronex	☐ Inject 140 mg SC every 2 weeks ☐ Inject 420 mg SC monthly	☐ 2 X 140 mg/ml ☐ 3 X 140 mg/ml ☐ 1 X 420 mg/ 3.5ml	
☐ Other				

PRESCRIBER INFORMATION

Physicain Name:_____ Address:_____

State License#:_____ NPI:_____ DEA:_____

Phone #:_____ Fax #:_____ Office Contact Name /Number:_____

Prescriber's Signature:_____ Date:_____

I authorize pharmax specialty pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.