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:	____________________

Prescription Information

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	☐ 2 x 140 mg/mL (28 days) ☐ 3 x 140 mg/mL (28 days) ☐ 6 x 140 mg/mL (84 days) ☐ 9 x 140 mg/mL (84 days)	☐ Auto Injector ☐ PFS	Refills: ______
	☐ Inject 420 mg subcutaneously monthly via onbody infuser over 9 minutes	☐ 420 mg/3.5 mL (1 month) ☐ 3 x 420 mg/3.5 mL (3 months)	☐ Pushtronex	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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