Hypercholesterolemia Prescription Referral Form

Sterling SPECIALTY PHARMACY

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www.sterlingspecialtyrx.com

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Date Medication Needed: _____ **Ship to:** ❑Patient's Home ❑Prescriber's Office ❑Pharmacy to Coordinate

1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: _____ Birthdate: _____ Sex: ❑Male ❑Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Primary Phone: _____ Secondary Phone: _____ Allergies: _____

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

Patient Email: _____ Caregiver Name: _____

2 Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____

3 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs & Tests with the prescription to expedite Prior Authorization.

Date of Diagnosis: _____ Primary ICD-10: _____ Secondary ICD-10: _____

Other: _____

Contraindications: Fibrates ❑Yes ❑No Statin: ❑Yes ❑No Niacin ❑Yes ❑No

If yes: ❑Myopathy or Rhabdomylosis ❑Hepatic Disease ❑Renal Dysfunction ❑Pregnancy or Lactation

❑Recent Stroke or TIA ❑Other: _____

Laboratory Tests:

❑Lipid Panel ❑No ❑Yes Date: _____

❑Liver Function ❑No ❑Yes Date: _____

❑Renal Function ❑No ❑Yes Date: _____

Prior Failed Therapies:	Indicate Drug Name & Length of Treatment:
❑ Fibrates	
❑ Niacin	
❑ Omega-3	
❑ Statin	
❑ Others	
❑	

If labs must be obtained from another prescriber, please indicate name here: _____

Injection Training: ❑ Pharmacist to Provide ❑ Patient Trained in MD Office ❑Manufacturer Nurse Support

If Prior Authorization is Denied: ❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

4 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dose/Strength	Direction	Qty.	Refills
❑ PRALUENT™	❑ 75mg/ml Pre-filled Pen	❑ Inject 75mg SC every 2 weeks	2	
	❑ 150mg/ml Pre-filled Pen	❑ Inject 150mg SC every 2 weeks ❑ Inject 300mg SC every 4 weeks	2	
❑ REPATHA™	❑ 140mg/ml SureClick® Auto Injector	❑ Inject 140mg SC every 2 weeks	2	
		❑ Inject 420mg SC once a month (Inject three 140mg/ml injections consecutively within 30 minutes)	3	
	❑ 420mg/3.5ml Pushtronex® system ❑ 140mg/mL pre-filled syringe	❑ Inject single use Pushtronex® system on body with prefilled cartridge	1 Pack	
❑ OTHER	_____	_____		

Prescriber Signature: Prescriber, please sign and date below:

Dispense as written: Date: Substitution Permissable: Date:

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services and patient assistance programs.

# of Prescriptions: _____