Dyslipidemia Medication Referral Form

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

INFORMATION

Ship to:	**Injection training provided by:**
☐ Patient	☐ Prescriber's office
☐ Physician/clinic	☐ Specialty Pharmacy
☐ 1st dose to Physician/clinic, remaining refills to patient	☐ Manufacturer
	☐ Other: ________________

DIAGNOSIS

Description / ICD-10 Code

☐ E78.01 Familial Hypercholesterolemia

Type: ☐ HeFH (Heterozygous) ☐ HoFH (Homozygous)

☐ E78.0 Pure Hypercholesterolemia

☐ E78.2 Mixed Hyperlipidemia

☐ E78.4 Other Hyperlipidemia

☐ E78.5 Unspecified Hyperlipidemia

Secondary ICD-10

☐ E08._____Diabetes Mellitus due to underlying condition

☐ E13._____Other Specified Diabetes Mellitus

☐ I10 Hypertension

☐ I25._____Chronic Ischemic Heart Disease

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

☐ Patient demographics ☐ Prescription card (front and back) ☐ Clinic notes and labs (including most recent lipid panel)

Last 4 Digits of Social:____________ Current LDL-C:________mg/dl Date:________________ Allergies:________________

Past medical history includes: ☐ Myocardial infarction ☐ Stable or unstable angina ☐ Coronary/arterial revascularization ☐ Peripheral arterial disease

☐ Rhabdomyolysis ☐ Other:____________________________________

☐ Intolerance to statins (list medications and dose failed):____________________________________

☐ Rhabdomyolysis ☐ Myositis ☐ Myalgia ☐ Baseline LFT's____________________________________

Previous treatment	☐ Atorvastatin (Lipitor) ☐ Rosuvastatin (Crestor) ☐ Simvastatin (Zocor) ☐ Ezetimibe (Zetia) ☐ Other statin/lipid lowering agent(s):____________________________________

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
Nexletol	180mg	Take one tablet by mouth once daily with or without food		
Nexlizet	180mg/10mg	Take one tablet by mouth once daily with or without food		
Praluent	☐ 75mg/ml Pen ☐ 150mg/ml Pen	Inject ______SQ every 2 weeks Inject 300mg (two 150mg injections) SQ every 4 weeks Other:______________________________	1 month supply Other:________________	
Repatha	☐ 140mg/ml Sureclick pen ☐ 140mg/ml PFS ☐ 420mg/3.5ml Pushtronex	Inject ______ SQ every 2 weeks Inject 420mg SQ once monthly	1 month supply Other:________________	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone: ____________________ Physician's NPI#: ____________________ Physician's Fax# : ____________________ Physician's Address: ____________________

Dispense as Written: ____________________ Printed Name: ____________________ Substitution Allowed: ____________________ Date: ____________________

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

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