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.
The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

V 8.23.21