Ochsner Specialty Pharmacy

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Cardiology

Patient's Information		
Patient Name		
Address		
City/State/Zip		
Telephone	Alternate Telephone	
Social Security #	Weight	Height
Date of Birth	❑ Male ❑ Female	

Prescriber Information		
Prescriber Name		Date
DEA #	NPI #	UPIN #
Address		
City/State/Zip		
Phone	Fax	
Contact Person		

***Please attach a copy of the front and back of the patient's insurance card, if available**

Diagnosis and Clinical Information

Diagnosis: ❑ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH) ❑ E78.2 Mixed Hyperlipidemia ❑ E78.4 Other Hyperlipidemia
❑ E78.5 Unspecified Hyperlipidemia ❑ ASCVD Specifc Code(s) _____

Drug Allergies: _____

Please provide one secondary ICD-10-CM code: ❑ I20.0 Unstable Angina ❑ I20.9 Angina Pectoris, Unspecified ❑ I21.___ Acute Myocardial Infarction
❑ I22._____ Subsequent Myocardial Infarction ❑ I25._____ Chronic Ischemic Heart Disease ❑ I63._____ Cerebral Infarction
❑ I65._____ Occlusion and Stenosis of Cerebral Arteries, Extracranial ❑ I66._____ Occlusion and Stenosis of Cerebral Arteries, Intracranial
❑ I67._____ Other Cerebrovascular Diseases ❑ I70._____Atherosclerosis ❑ I73.9 Peripheral Vascular Disease, Unspecified
❑ G45.9 Transient Cerebral Ischemic Attack, Unspecified ❑ G46._____ Vascular Syndromes ❑ Other (specify ICD-10-CM):

_____ Most recent LDL-C level on treatment

_____ ☐ ☐ ☐ ☐ _____ Date _____ Prior and/or Current Treatments: ❑

Atorvastatin (Lipitor®) ❑ Ezetimibe (Zetia®) ❑ Pravastatin (Pravachol®) ❑ Rosuvastatin (Crestor®) ❑ Simvastatin (Zocor®)

Other _____

Dose _____ Length of Treatment _____ Reason for Discontinuing _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
Praluent™	❑ 75 mg/mL Pre filled Pen 2 pack ❑ 150 mg/mL Pre filled Pen 2 pack ❑ 75 mg/mL Pre filled Syringe 2 pack ❑ 150 mg/mL Pre filled Syringe 2 pack	❑ Inject subcutaneously once every 2 weeks	4 week supply	_____
Repatha™	❑ 140 mg/mL SureClick® 1 pack ❑ 140 mg/mL SureClick® 2 pack ❑ 140 mg/mL SureClick® 3 pack ❑ 140 mg/mL Pre filled Syringe 1 pack	❑ Inject subcutaneously once every 2 weeks ❑ Inject subcutaneously monthly (3 injections to be given consecutively within 30 minutes)	4 week supply	_____
	❑ 420 mg/3.5 mL single-use Pushtronex™ System	❑ Administer subcutaneously once monthly over 9 minutes by using the single-use on-body infusor with prefilled cartridge		

By signing this form and using our services, you are authorizing Ochsner Specialty Pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies. Prescriber Signature Below: (Physician attests that this is his/her legal signature. **NO STAMPS)**

_____
Prescriber's Signature Substitution Allowed

_____
Prescriber's Signature Dispense as Written