2825 W. A.J. Hwy. Morristown, TN 37814
Phone: 423-307-5757
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Please fax support documentation with RX to:
423-307-5241

urac ACCREDITED Specialty Pharmacy Expires 07/01/2021

ACHC ACCREDITED

FountainRx

Cardiovascular

Patient Information:

Name:_____
Address:_____
City:_____State:____Zip:_____
Phone:_____Alt Phone:_____
Email:_____
DOB:_____Height:_____Weight:_____
Gender: M F Caregiver:_____

Prescriber Information:

Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Fax:_____
NPI:_____DEA:_____
Tax ID:_____
Office Contact:_____Phone:_____

Drug Allergies:_____ **Latex Allergy?** **Yes** **No**

CLINICAL INFORMATION:

Primary Diagnosis:

□ **E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)**
□ **E78.2 Mixed Hyperlipidemia**
□ **E78.4 Other Hyperlipidemia**
□ **E78.5 Unspecified Hyperlipidemia**
□ **ASCVD Specific Codes:**_____

Secondary Diagnosis:

□ **I20.0 Unstable Angina**
□ **I20.9 Angina Pectoris, Unspecified**
□ **I21.____ Acute Myocardial Infarction**
□ **I22.____ Subsequent Myocardial Infarction**
□ **G45.9 Transient Cerebral Ischemic Attack**
□ **I63.____Cerebral Infarction**
□ **I73.9 Peripheral Vascular Disease**
□ **I70.____ Atherosclerosis**
□ **G46.____ Vascular Syndromes**
□ **Other (ICD-10 Code):**_____

Prior Failed Medications:

□ **Atorvastatin** Length of Treatment:_____Reason for Discontinuing:_____
□ **Pravastatin** Length of Treatment:_____Reason for Discontinuing:_____
□ **Rosuvastatin** Length of Treatment:_____Reason for Discontinuing:_____
□ **Simvastatin** Length of Treatment:_____Reason for Discontinuing:_____
□ **Ezetimibe** Length of Treatment:_____Reason for Discontinuing:_____

Homozygous Familial Hypercholesterolemia (HoFH):

□ **Cutaneous or tendon xanthoma before age 10 years**
□ **Untreated elevated LDL-C levels consistent with heterozygous FH in both parents - untreated total cholesterol > 290mg/dl (>7.5mmol/L) or LDL-C > 190mg/dl (>4.9mmol/L)**
□ **Genetic Confirmation of two mutant alleles at the LDLR, Apo-B, PCSK9, ARH adaptor protein 1/LDLRAP1 gene locus**

Heterozygous Familial Hypercholesterolemia (HeFH):

□ **Yes** □ **No** **The patient has a first or second degree relative with a pretreatment cholesterol of >290mg/dl (>7.5 mmol/L)**

ASCVD Pooled Cohort Risk Assessment Score:_____**Framingham Risk Score:**_____

PLEASE FAX COPIES: □ **Medical Card (Front and Back)** □ **Prescription Card (Front and Back)** □ **Clinical Notes**

INJECTION TRAINING: □ **Trained in Provider Office** □ **Manufacturer Support** □ **Trained by Pharmacist**

Medication	Dosage and Strength	Directions	Quantity	Refills
□ **Praluent®**	□ 75mg/ml Prefilled Pen (2-Pack) □ 150mg/ml Prefilled Pen (2-Pack)	□ Inject 75mg SC every other week □ Inject 150mg SC every other week □ Inject 300mg SC every 4 weeks	1 1 1	____
□ **Repatha®**	□ 140mg/ml SureClick® (2-Pack) □ 140mg/ml pre-filled syringe (1-Pack) □ 420mg/3.5ml single-use Pushtronex®	□ Inject 140mg SC every other week □ Inject 420mg SC every month (3 injections SC 30 minutes apart) □ Inject 420mg SC every month (over 9 minutes via single-use on-body infuser with prefilled syringe).	1 3 1	____
□ **Other**	□ _____	□ _____		

By signing this form and utilizing our services, you are authorizing Fountain Plaza Pharmacy, LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature:_____ **Date:**_____