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FountainRx

Cardiovascular

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

Patient Information:	**Prescriber Information:**
Name:________________	Name:________________
Address:________________	Address:________________
City:__________ State:____ Zip:______	City:__________ State:____ Zip:______
Phone:__________ Alt Phone:__________	Phone:__________ Fax:__________
Email:________________	NPI:__________ DEA:__________
DOB:______ Height:______ Weight:______	Tax ID:________________
Gender: M F Caregiver:__________	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:

Medication	Dose	Length of Treatment	Reason for Discontinuing
☐ **Atorvastatin**	______**mg**	Length of Treatment:__________	Reason for Discontinuing:__________
☐ **Pravastatin**	______**mg**	Length of Treatment:__________	Reason for Discontinuing:__________
☐ **Rosuvastatin**	______**mg**	Length of Treatment:__________	Reason for Discontinuing:__________
☐ **Simvastatin**	______**mg**	Length of Treatment:__________	Reason for Discontinuing:__________
☐ **Ezetimibe**	______**mg**	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)	☐ Inject 140mg SC every other week	1	
	☐ 140mg/ml pre-filled syringe (1-Pack)	☐ Inject 420mg SC every month (3 injections SC 30 minutes apart)	3	
	☐ 420mg/3.5ml single-use Pushtronex®	☐ Inject 420mg SC every month (over 9 minutes via single-use on-body infuser with prefilled syringe).	1	
☐ **Other**				

By signing this form and utilizing our services, you are authorizing FountainRx 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:**______________