Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS
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Hypercholesterolemia Referral Form

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location): _____ Date Needed: _____ ❑Need Nurse ❑Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	
Sex: ❑ Male ❑Female Weight lbs/kg Height	
Allergies:	

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
❑E78.0 Pure Hypercholesterolemia (including HeFH & HoFH)
❑E78.2 Mixed Hyperlipidemia
❑E78.4 Other Hyperlipidemia
❑E78.5 Hyperlipidemia, unspecified
❑Other_____

Baseline LDL-C_____mg/dL Date:_____
Current LDL-C _____mg/dL Date:_____

Past Medical History Includes:
❑Myocardial infarction
❑Coronary/arterial revascularization (PTCA, CABG)
❑Stroke or transient ischemic attack (TIA)
❑ Peripheral arterial disease
❑Stable or unstable angina
❑Chronic Ischemic Heart Disease ❑Cerebral Infarction
❑De-compensated liver disease ❑Acute Liver Disease
❑Rhabdomyolysis ❑Myalgia ❑Myositis

Diagnosis confirmed by:
❑WHO/Dutch Lipid Clinic Network Familial Hypercholesterolemia diagnostic criteria score of _____.
❑Other_____

Prior Treatment History *(select all that apply & please attach list if necessary)*
Atorvastatin (Lipitor) 10mg 20mg 40mg 80mg Dates:_____
Rosuvastatin (Crestor) 5mg 10mg 20mg 40mg Dates:_____
Simvastatin (Zocor) 5mg 10mg 20mg 40mg 80mg Dates:_____
Ezetimibe (Zetia) 10mg Dates:_____
Other statin/lipid lowering agent(s):_____ Dates:_____
Does patient have any contraindications or intolerances to any medications? ❑Yes ❑No
If yes, please name medication and describe contraindication or reaction? _____

Current Therapy: Product & Dose:_____ Start Date:_____
Will patient be discontinuing any current medication(s) before starting new medication? ❑Yes ❑No

Labs: *please include copy of most recent lab work results*
ALT:_____Date:_____ AST:_____Date:_____
Hgb _____Date:_____ Platelet:_____Date:_____
Albumin_____Date:_____ Serum creatinine:_____ Date:_____
Creatine Kinase:_____Date:_____

For Atherosclerotic Cardiovascular Disease (ASCVD):
ASCVD Pooled Cohort Risk Assessment Score *(if applicable)*:_____
OR
Framingham Risk Score *(if applicable)*: _____

PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Praluent® *(alirocumab)*	❑ 75mg/mL Pen ❑ 75mg/mL PFS	❑ Inject 75mg SC every 2 weeks	1 Carton=2 x 75mg/mL	
	❑ 150mg/mL Pen ❑ 150mg/mL PFS	❑ Inject 150mg SC every 2 weeks	1 Carton= 2 x 150mg/mL	
Repatha™ *(evolocumab)*	❑ 140mg/mL PFS ❑ 140mg/mL SureClick®	❑ Inject 140mg SC every 2 weeks ❑ Inject 420mg SC every 4 weeks *(3 injections must be given within 30 consecutive minutes each month)*	1 pack= 1 x 140mg/mL PFS 1 pack= 1 x 140mg/mL SureClick® 2 pack= 2 x 140mg/mL SureClick® 3 pack= 3 x 140mg/mL SureClick®	
Other	_____	❑ _____		
Other	_____	❑ _____		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payors, processors and other entities.*

Prescriber's Signature: _____ Date:_____