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.

Twin Oaks Specialty Pharmacy

Your Specialty Partner
Phone: 855-793-TOSP (8677)
Fax: 855-909-TOSP (8677)

Hypercholesterolemia Referral Form

Date Medication Needed: _____ **Ship To:** Patient's Home Prescriber's Office Injection training by pharmacy? ☐

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** ☐ Male ☐ Female **Height:** _____ **Weight:** _____ ☐ lbs. ☐ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Alt. Caregiver Name: _____ **Phone:** _____ **Comorbidities:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Clinical Information

ICD-10 Codes and Diagnosis

Primary ICD-10 (must select one)

- ☐ E78.01 Familial hypercholesterlemia
- ☐ E78.5 Hyperlipidemia, unspecified
- ☐ E78.2 Mixed Hpyerlipidemia

Secondary ICD-10 (select all that apply)

- ☐ Z83.42 Family history of familial hypercholesterolemia
- ☐ 120.0 Unstable Angina
- ☐ 120.9 Angina Pectoris
- ☐ 121.___ Acute Myocardial Infaction
- ☐ 122.___ Subsequent Myocardial Infarction
- ☐ 125.___ Chronic Ischemic Heart Disease
- ☐ 163.___ Cerebral Infarction
- ☐ 165.___ Occlusion and stenosis of Cerebral Arteries, Intracranial
- ☐ 167.___ Other Cerebrovascular Diseases
- ☐ Other, Specify ICD-10 _____

Previous Treatment (select all that apply)

- Atorvastatin (Lipitor) ☐ 10mg ☐ 20mg ☐ 40mg ☐ 80mg Date(s): _____
- Rosuvastatin (Crestor) ☐ 5mg ☐ 10mg ☐ 20mg ☐ 40mg Date(s): _____
- Simvastatin (Zocor) ☐ 5mg ☐ 10mg ☐ 20mg ☐ 40mg ☐ 80mg Date(s): _____
- Ezetimibe (Zetia) ☐ 10mg Date(s): _____

Other statin/lipid lowering agent(s): _____

Current therapy: _____

Achieved maximum tolerated statin dose? ☐ Yes ☐ No

Lab Results:

please attach a copy of patients most recent lipid panel LDL-C _____ mg/ml Date: _____

Intolerance to statins (list medications and dose failed): _____

Rationale for Discontinuation: ☐ Rhabdomyalosis ☐ Myositis ☐ Myalgia

Baseline LFT's: _____

3: Prescription Information

Medication	Strength	Directions	Qty.	Refills
Praluent®	☐ 75 mg/mL Pen	☐ Inject subcutaneously every 2 weeks	☐ 1 month supply	
	☐ 150 mg/mL Pen	☐ Inject 150mg every 2 weeks ☐ Inject 300mg (in two separate locations) monthly	☐ Other: _____	
Repatha™	☐ 140 mg/mL SureClick® ☐ 420 mg/3.5mL Pushtronex®	☐ Inject 140 mg sub-Q every 2 weeks ☐ Inject 420 mg sub-Q every 4 weeks	☐ 1 month supply ☐ Other: _____	

4: Injection Training

☐ **Patient received injection training** ☐ **Prescriber's office to provide injection training** ☐ **Twin Oaks Injection Training**

5: Prescriber Information

Prescriber Name: _____ **office contact:** _____

preferred method of contact: ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:** _____

ship to: ☐ **patient** ☐ **office** ☐ **alternate** _____ (shipping address) _____ (street) _____ (city) _____ (state) _____ (zip)

office address: _____ (street, suite, city, state, zip)

phone: _____ **fax:** _____ **NPI:** _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissible Date

I authorize Twin Oaks Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

# of Prescriptions: _____

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.