Cardiology Enrollment Form

InfuCare Rx

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Website: www.InfuCareRx.com

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Name:			Prescribing Practitioner:		NPI:
Address:			Address:		
City:	State/Zip:		City:		State/Zip:
Telephone:	DOB:	M ☐ F ☐	Office:		DEA:
Language Preference:	Wt:	Ht:	Contact:	Phone:	Fax:

PLEASE FAX COPY OF: ☐ PRESCRIPTION FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

PRIMARY INSURANCE INFORMATION

Member Name:	M ☐ F ☐	DOB:	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****	

PRESCRIPTION

New ☐ Refill ☐ Ship by: Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug	Strength	Directions	Quantity	Refills
Praluent®	☐ 75mg Pen ☐ 75mg PFS ☐ 150mg Pen ☐ 150mg PFS	☐ Inject 75mg SubQ every 2 weeks ☐ Inject 150mg SubQ every 2 weeks	1 month supply	
Repatha®	☐ 140mg/mL SureClick® ☐ 420 mg/3.5mL single-use Pushtronex™ System	☐ Inject 140-mg/mL subcutaneously using a SureClick® autoinjector every 2 weeks ☐ Administer 420-mg/3.5mL subcutaneously using a Pushtronex™ system (on body infusor with prefilled cartridge) once monthly	1 month supply	
Zontivity®	☐ 2.08mg	☐ Take 1 tablet by mouth once daily	1 month supply	
Other:				

DIAGNOSIS AND CLINICAL INFORMATION

***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

☐ 150.20 Systolic Heart Failure unspecified
☐ 150.22 Systolic Heart Failure Chronic
☐ E78.0 Pure Hypercholesterolemia (Including HeFH and HoFH)
☐ E78.2 Mixed Hyperlipidemia
☐ E78.4 Other Unspecified Hyperlipidemia
☐ 125.10 Atherosclerotic Cardiovascular Disease
☐ Other: _____

Prior Medication Failed: _____
Length of Treatment:_____
Reason for Discontinuation: _____

Beta Blockers: ☐ Carvedilol ☐ Metroprolol Succinate ☐ Other:_____
Beta-blocker dose:_____
Stable at Maximum Tolerated Dose: ☐ Yes ☐ No
Not on beta-blocker due to: ☐ beta-blocker intolerance ☐ beta-blocker contraindication
ACEs: ☐ Lisinopril ☐ Enalapril ☐ Ramipril ☐ Other:_____
ARBs: ☐ Losartan ☐ Valsartan ☐ Other:_____
Resting Heart Rate: ☐ > 70 BPM or enter rate _____ In Sinus Rhythm ☐ Yes ☐ No
Left Ventricular Ejection Fraction ≤ 35%?: ☐ Yes _____
LDL-C Treatment: ☐ Atovastatin ☐ Rosuvastatin ☐ Simvastatin ☐ Ezetimibe ☐ Other
Dose: _____

Allergies:

Additional Clinical Information:

INJECTION TRAINING:

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ FOSRX/FAST to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: **Date:**