InfuCare Rx

Cardiology Referral Form

of Pages Faxed: ___________
Fax Referral To: 844-504-3278
Phone: 877-327-8881

Date Required: ________________________ Ship To: ☐ Patient ☐ MD Office ☐ Other: ________________

PATIENT INFORMATION

Patient Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Home Phone: ______________________
Cell Phone: ______________________
Date of Birth: ______________ ☐ Male ☐ Female
Emergency Contact: ______________ Phone: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________________
Fax: ______________________
DEA #: ______________ NPI #: ______________
Contact Person: ______________________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______________ ID: ______________ Group: ______________
Secondary Insurance: ______________ ID: ______________ Group: ______________
Prescription Card: ______________ ID: ______________ BIN: ______________ PCN: ______________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ 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: ______________________

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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: ______________
Weight: ________ ☐ kg ☐ lbs Height: ________ ☐ cm ☐ in %BSA: ________
Allergies: ______________________ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: ______________

PRESCRIPTION INFORMATION

Medication:	Dose/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:				

ADDITIONAL COMMENTS

Prescriber Signature: ______________________ Date: ______________

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