InfuCare Rx

Cardiology Enrollment Form

Fax Referral To: 844-533-1131
Phone: 877-327-8881

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
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 per mL SureClick® ☐ 420 mg per 3.5mL single-use Pushtronex™ System	☐ Inject 140-mg per mL SUBQ using a SureClick® autoinjector every 2 weeks ☐ Administer 420-mg per 3.5mL SUBQ using a Pushtronex™ system (on bodyinfusor 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:** _____