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® 420mg per 3.5mL single-use Pushtronex™ System	Inject 140mg per mL SUBQ using a SureClick® autoinjector every 2 weeks Administer 420mg 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:** ________

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