CARDIOVASCULAR DISEASES SPECIALTY CARE PROGRAM

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Tax I.D.: _____

Office Contact: _____ Phone: _____

Specialty: ❑ **Cardiology** ❑ **Lipidology** ❑ **Other** _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation and Laboratory Results)

Date of Diagnosis: _____ Primary ICD-10: _____ Secondary ICD-10: _____ Other: _____

For Heart Failure:
For patients with Heart Failure, please specify the class:
❑ NYHA Class I ❑ NYHA Class II ❑ NYHA Class III ❑ NYHA Class IV
❑ Echocardiogram or ❑ Electrocardiogram
Ejection Fraction: _____ Date: _____
Prior Failed Therapy: ❑ ACEi/ARBs ❑ Aldosterone Antagonists
❑ Beta Blockers ❑ Diuretics ❑ Other _____
Contraindications: ❑ Yes ❑ No If yes: ❑ Angioedema
❑ Hepatic Failure ❑ Renal Insufficiency ❑ Other _____

If labs must be obtained from another prescriber,
please indicate name here: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

For Hypercholesterolemia:
Laboratory Tests:
❑ Lipid Panel ❑ No ❑ Yes Date: _____
❑ Liver Function ❑ No ❑ Yes Date: _____
❑ Renal Function ❑ No ❑ Yes Date: _____
Prior Failed Therapy: ❑ Fibrates ❑ Niacin ❑ Omega-3
❑ Statin ❑ Other _____
Contraindications:
Fibrates: ❑ Yes ❑ No Statin: ❑ Yes ❑ No Niacin: ❑ Yes ❑ No
If yes: ❑ Myopathy or Rhabdomyolysis ❑ Hepatic Disease
❑ Renal Dysfunction ❑ Pregnancy or Lactation
❑ Recent Stroke or TIA ❑ Other _____

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ ENTRESTO®	Initiate ❑ 24mg/26mg or ❑ 49mg/51mg Titrate to ❑ 49mg/51mg or ❑ 97mg/103mg Maintenance ❑ 97mg/103mg	❑ Take 1 tablet twice daily for 2-4 weeks as directed ❑ Take 1 tablet twice daily for 2-4 weeks as directed ❑ Take 97mg/103mg tablet twice daily	❑ 60 ❑ 80 ❑ 1 Pack	
❑ PRALUENT®	❑ 75mg/ml Pre-filled Pen ❑ 75mg/ml Pre-filled Syringe	❑ Inject 75mg SC every 2 weeks	2	
	❑ 150mg/ml Pre-filled Pen ❑ 150mg/ml Pre-filled Syringe	❑ Inject 150mg SC every 2 weeks	2	
❑ REPATHA®	❑ 140mg/ml Pre-filled Syringe ❑ 140mg/ml SureClick® Auto Injector	❑ Inject 140mg SC every 2 weeks	2	
		❑ Inject 420mg SC once a month *(Inject three 140mg/ml injections consecutively within 30 minutes)*	3	
	❑ 420mg/3.5ml Pushtronex™ system	❑ Inject single use Pushtronex™ system on body with prefilled cartridge	1 Pack	
❑ OTHER _____	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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