REPATHA PRESCRIPTION REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960
Tel : 973 - 998 - 0287 | Fax : 973 - 998 - 0288
Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date ______

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Last updated: May 2017

Patient Name ______ SS# ______ DOB ______ Height ______ Weight ______ ☐ Male ☐ Female
Street Address ______ Apt # ______ City ______ State ______ Zip ______
Evening Tel ______ Cell ______ ☐ Text Message Allowed Email ______
Caregiver Name ______ Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy
Allergies ______ Comorbidities ______
Current Medications (if necessary, please fax a complete list) ______

ICD-10 Diagnosis: ☐ E78.0 Pure Hypercholesterolemia ☐ E78.2 Mixed Hyperlipidemia ☐ E78.4 Other Hyperlipidemia ☐ E78.5 Hyperlipidemia, unspecified
Please add one **secondary** ICD-10-CM code: ______
Weight______ Blood Pressure ______ Current smoker? ☐ Yes ☐ No LDL-C Value ______ mg/dL on date______

Insured's Name ______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______
Prescription Card ☐ Yes ☐ No If Yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______
Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PREVIOUS OR CURRENT LIPID LOWERING TREATMENTS

☐ none

	Strength/Freq	*Dates of Therapy*
☐ Atorvastatin (Lipitor®)	______mg/ ______	mm/yy ______ to ______
☐ Ezetimibe (Zetia®)	______mg/ ______	mm/yy ______ to ______
☐ Pravastatin (Pravachol®)	______mg/ ______	mm/yy ______ to ______
☐ Rosuvastatin (Crestor®)	______mg/ ______	mm/yy ______ to ______
☐ Simvastatin (Zocor®)	______mg/ ______	mm/yy ______ to ______
☐ Other______	______mg/ ______	mm/yy ______ to ______
☐ Other______	______mg/ ______	mm/yy ______ to ______

REPATHA® (evolocumab)

☐ 140 mg/ml single-use prefilled SureClick® autoinjector

SIG: Inject 140 mg subcutaneously every 2 weeks

QTY: ☐ 1 month supply
☐ 3 month supply
☐ Other ______

Refills ______

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. PLEASE NOTE: Morristown Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

Please fax completed form to **Morristown Pharmacy** at **973 - 998 - 0288**

Visit us at **WWW.MORRISTOWNRX.COM** for online fillable forms.

© Morristown Pharmacy Inc 2021