HealthQuest
Infusion & Specialty

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T 832.612.3500 **F** 866.612.3437

HYPERCHOLESTEROLEMIA REFERRAL FORM

E-SCRIPTS: NCPDP# 5902944 NPI# 1720383003

ACHC ACCREDITED

DATE _____ DATE NEEDED _____

SHIP TO: ☐ Patient ☐ Physician's Office ☐ HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____ E-mail _____
Date of Birth _____ SS # _____
☐ Female
☐ Male

Prescriber's Name _____
License # _____ DEA # _____
NPI # _____ UPIN # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

ICD-10 DIAGNOSIS CODE ☐ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH) ☐ E78.2 Mixed Hyperlipidemia
☐ E78.4 Other Hyperlipidemia ☐ E78.5 Hyperlipidemia, unspecified

SECONDARY ICD-10 (check all that apply) ☐ 120.0 Unstable Angina ☐ 120.9 Angina Pectoris ☐ 121.0 Acute Myocardial Infarction
☐ 122.0 Subsequent Myrocardial Infarction ☐ 125.0 Chronic Ischemic Heart Disease ☐ 163.0 Cerebral Infarction
☐ 165.0 Occlusion and stenosis of cerebral arteries, Intracranial ☐ Other Cerebrovascular Diseases ☐ Other, specify ICD-10: _____

Previous Treatment (check all that apply) ☐ Atorvastatin (Lipitor) ☐ Rosuvastatin (Crestor) ☐ Simvastatin (Zocor) ☐ Ezetimibe (Zetia)
Other statin/lipid lowering agent(s) _____

Current Therapy _____ Dose: _____ Date started: _____ Achieved max. statin dose? ☐ Yes ☐ No

Please attach copy of patient's most recent lipid panel

Intolerance to statins (list medications and dose failed): _____

☐ Rhabdomyalosis ☐ Myositis ☐ Myalgia Baseline LFTs: _____

PRESCRIPTION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Praluent®	☐ 75 mg/mL Pen ☐ 75 mg/mL PFS ☐ 150 mg/mL Pen ☐ 150 mg/mL PFS	☐ Inject sub-Q every 2 wks. ☐ Other: _____	☐ 4 wk. supply	
Repatha®	☐ 140mg/mL PFS ☐ 140 mg/mL SureClick	☐ Inject 140mg sub-Q every 2 wks. ☐ Inject 420 mg sub-Q every 4 wks.	☐ 4 wk. supply	

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____