PUBLIX PHARMACY
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Heart Failure Referral Form

Publix Specialty Pharmacy (#3212)

7616 Southland Blvd, Suite 112
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs and office notes]

Diagnosis Code: ☐ I50.20 (Unspecified systolic heart failure) ☐ I50.22 (Chronic systolic heart failure) ☐ I50. _____

Treatment status: ☐ New to therapy, previously denied by insurance: ☐ No ☐ Yes, include copy of denial letter

☐ Continuation of therapy, start date: ___/___/_____ Is the patient on samples? ☐ No ☐ Yes

Enroll in free trial/ copay card/ bridge program if available and eligible: ☐ No ☐ Yes

NYHA Functional Class: ☐ II ☐ III ☐ IV Left ventricular ejection fraction (LVEF): _____ %

B-type natriuretic peptide level (BNP): _____ pg/mL NT-proBNP: _____ pg/mL

Rhythm: ☐ Normal sinus rhythm ☐ Other: _____ Resting HR: _____ bpm, BP: _____/_____ mmHg

Beta-blocker therapy: ☐ Active, name and dose: _____

☐ Contraindicated/failed, describe: _____

ACE-I/ARB therapy: ☐ Active, name and dose: _____

☐ Contraindicated/failed, describe: _____

Other pertinent past medical history and/or drug therapy: _____

Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in Allergies: ☐ NKDA ☐ Other: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY FOR	REFILLS
☐ Corlanor (ivabradine)	☐ 5 mg tablet ☐ 7.5 mg tablet *Note: NOT available in 2.5mg tablet*	☐ Take 1 tab PO BID with meals	☐ 30 days ☐ 90 days	_____
		☐ Take one-half tab (2.5mg) PO BID with meals	☐ 30 days ☐ 90 days	_____
☐ Entresto (sacubitril/ valsartan)	☐ 24/26 mg tablet ☐ 49/51 mg tablet ☐ 97/103 mg tablet	Take 1 tab PO BID	☐ 30 days ☐ 90 days	_____
☐ Other: _____	_____	_____	_____	_____

Prescriber Information [Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____] Use Cover My Meds: ☐ Yes ☐ No

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ _____
(stamps not accepted) ☐ Substitution allowed Date ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here: