PUBLIX PHARMACY
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Hyperlipidemia Referral Form

Publix Specialty Pharmacy (#3212)

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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: ☐ E78.0 (Pure hypercholesterolemia) ☐ E78.2 (Mixed hyperlipidemia) ☐ E78.4 (Other hyperlipidemia) ☐ E78. _____

Indication: ☐ Hyperlipidemia with clinical ASCVD, select event(s): ☐ Myocardial infarction ☐ Unstable/stable angina ☐ Coronary revascularization ☐ Ischemic stroke ☐ Transient ischemic attack ☐ Peripheral arterial disease

☐ Heterozygous familial hypercholesterolemia (HeFH), include Dutch Lipid Clinic Network score: _____

☐ Homozygous familial hypercholesterolemia (HoFH), include Dutch Lipid Clinic Network score: _____

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

LDL-C: ☐ Baseline (prior to PCSK9 inhibitor): _____mg/dL, Date: ___/___/_____

☐ Current (within 30 days): _____mg/dL, Date: ___/___/_____

Statin use: ☐ Active therapy, name and dose: _____

☐ Contraindicated/failed, describe: _____

Fill in Statin History:

__ Crestor (rosuvastatin)	☐ 5mg	☐ 10mg	☐ 20mg	☐ 40mg	Start Date ___/___/____ End Date ___/___/___
__ Lipitor (atorvastatin)	☐ 10mg	☐ 20mg	☐ 40mg	☐ 80mg	Start Date ___/___/____ End Date ___/___/___
__ Zocor (simvastatin)	☐ 5mg	☐ 10mg	☐ 20mg	☐ 40mg	Start Date ___/___/____ End Date ___/___/___
__ Pravachol (pravastatin)	☐ 10mg	☐ 20mg	☐ 40mg	☐ 80mg	Start Date ___/___/____ End Date ___/___/___
__ Livalo (pitavastatin)	☐ 1mg	☐ 2mg	☐ 4mg		Start Date ___/___/____ End Date ___/___/___
__Other: _____	Dose: _____ mg				Start Date ___/___/____ End Date ___/___/___

Zetia (ezetimibe) use: ☐ Active, dose: _____mg ☐ Never tried

☐ Contraindicated/failed, describe: _____ Start Date ___/___/____ End Date ___/___/___

Other lipid lowering med(s): ☐ Active, name and dose: _____

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

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY FOR	REFILLS
☐ Praluent (alirocumab)	☐ 75 mg/mL prefilled pen ☐ 150 mg/mL prefilled pen	Inject SC every 2 weeks as adjunct to diet	☐ 28 days ☐ 84 days	_____
	☐ 150 mg/mL prefilled pen	Inject 300 mg (2 x 150 mg) SC every 4 weeks as adjunct to diet	☐ 28 days ☐ 84 days	_____
☐ Repatha (evolocumab)	☐ 140 mg/mL SureClick pen ☐ 140 mg/mL prefilled syringe	Inject 140 mg SC every 2 weeks as adjunct to diet	☐ 28 days ☐ 84 days	_____
	☐ 420 mg/3.5mL Pushtronex	Administer 420 mg SC via on-body infusor once a month as adjunct to diet	☐ 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: