curexa Pharmacy

Hypercholesterolemia

toll free phone. 855.927.0390
toll free fax. 855.927.0392

Patient Information – *Please attach a copy of the patient's insurance card*

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:

Product Shipping Options: ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:

Prescriber Information

Practice Name:		Office Contact:	
Prescriber:		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Primary Diagnosis/ICD-10:	Secondary Diagnosis/ICD-10:

Has the diagnosis of ASCVD been confirmed by any of the following? *(select all that applies):*
☐ Intolerant to statins ☐ Patient has a history of clinical ASCVD
☐ Displays lack of adherence to hypercholesterolemia medications
☐ Patient has a history of cutaneous or tendinous xanthoma before age 10
☐ Stroke ☐ Transient ischemic attack ☐ Acute coronary syndromes
☐ Stable or unstable angina ☐ Coronary or other arterial revascularization

Contraindications for statin therapy:
☐ Active liver disease
☐ Unexplained persistent elevation of serum transaminases
☐ Pregnancy

Evidence of heterozygous familial hypercholesterolemia in both parents? ☐ Yes ☐ No
If yes, please provide all clinical/lab results that confirms diagnosis:

Confirmed generic mutation of the LDL receptor ApoB or PCSK9? ☐ Yes ☐ No If yes, please provide lab results.

Prior Failed Medications:

☐ Atorvastatin	_____ mg/day	dates:	
☐ Ezetimibe	_____ mg/day	dates:	
☐ Ezetimibe/simvastatin	_____ mg/day	dates:	
☐ Pravastatin	_____ mg/day	dates:	
☐ Rosuvastatin	_____ mg/day	dates:	
☐ Simvastatin	_____ mg/day	dates:	
☐ Pitavastatin	_____ mg/day	dates:	
☐ Other:	_____ mg/day	dates:	

Lab Results
LDL-C: _____ mg/mL
Result date: _____
AST: _____
ALT: _____
Creatine kinase: _____

Will the patient continue to receive high intensity statin therapy? ☐ Yes ☐ No

What other cardiovascular medications will the patient continue receiving? List all that apply:

Prescription Information

Medication	Dose	Directions	Quantity	Days Supply	Refills
☐ Praluent®	☐ 75 mg/mL prefilled pens ☐ 150 mg/mL prefilled pens	☐ Inject 75 mg sub-Q every 2 weeks ☐ Inject 150 mg sub-Q every 2 weeks ☐ Inject 300 mg sub-Q every 4 weeks	☐ 2 prefilled pens ☐ 6 prefilled pens	☐ 28 days ☐ 84 days	
☐ Repatha™	☐ 140 mg/mL prefilled syringe ☐ 140 mg/mL SureClick®	☐ Inject 140 mg sub-Q every 2 weeks	☐ 2 prefilled syringe ☐ 2 SureClick® pens ☐ 6 prefilled syringes ☐ 6 SureClick® pens	☐ 28 days ☐ 84 days	
	☐ 420 mg/mL PushTronex™	☐ Inject 420 mg sub-Q every 4 weeks	☐ 1 PushTronex™ system with prefilled cartridge ☐ 3 PushTronex™ system with prefilled cartridge	☐ 30 days ☐ 90 days	

Prescriber Signature and Date (Please sign and date below)

_____ Dispense as Written _____ Date

_____ Substitution Permissible _____ Date

Prescriber Specialty: _____

☐ Check here to authorize Curexa™ and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"