



PCSK9 Referral Form

Patient Demographics: Please attach a copy of patient's insurance card (front and back)

First Name:	Last Name:	Date of Birth:	M <input type="checkbox"/> F <input type="checkbox"/>
Address:	City:	State:	Zip:
Phone:	Social Security #:	Allergies:	

Diagnosis and Clinical Information:

(Attach ASCVD history, clinical notes, lab work, and prior medication history)

LDL-C: _____ (Current) Diagnosis Code (ICD-10): <input type="checkbox"/> E78.0 Pure Hypercholesterolemia (HeFH/HoFH) <input type="checkbox"/> E78.2 Mixed Hyperlipidemia <input type="checkbox"/> E78.4 Other Hyperlipidemia <input type="checkbox"/> E78.5 Hyperlipidemia, unspecified Other(s): _____	Treatment History: Atorvastatin: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 Date(s): _____ Pravastatin: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 Date(s): _____ Rosuvastatin: <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 Date(s): _____ Simvastatin: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 Date(s): _____ Ezetimibe: <input type="checkbox"/> 10 Date(s): _____ Other: _____ Date(s): _____ Reason for Discontinuation: _____
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Prescription Information:

Drug	Strength	Directions	Quantity	Refills
Repatha	<input type="checkbox"/> 140mg/ml SureClick	<input type="checkbox"/> Inject the contents of one pen (140mg) subQ every two weeks	<input type="checkbox"/> 2	
	<input type="checkbox"/> 420mg/3.5ml Pushtronex	<input type="checkbox"/> Inject one cartridge (420mg) subQ every month	<input type="checkbox"/> 1	
Praluent	<input type="checkbox"/> 75mg/ml Pen	<input type="checkbox"/> Inject the contents of one pen subQ every two weeks	<input type="checkbox"/> 2	
	<input type="checkbox"/> 150mg/ml Pen	<input type="checkbox"/> Inject 300mg (two pens) subQ once every four weeks. Inject syringes simultaneously, using different injection sites.		

Prescriber Information:

Name:	NPI:	DEA:	
Address:	City:	State:	Zip:
Phone:	Fax:	Specialty:	Office Contact:

Updated April 2020

Prescriber Signature: _____ **Date:** _____

By signing this form and utilizing our services, you are authorizing Barney's Specialty Pharmacy to serve as your designated prior authorization agent in dealing with third party payors. Pharmacy is also authorized to investigate patient insurance benefits and will also explore financial assistance for patient via pharmaceutical manufacturer programs and patient assistance foundations.