Galaxy SPECIALTY PHARMACY
(Christus SantaRosa Hospital, Tower # 1)

Faxed prescriptions will only be accepted from a prescribing practitioner.
Patients must bring an original prescription to the pharmacy.

CARDIOLOGY REFERRAL FORM

2829 Babcock Road, Suite # 120 • San Antonio- 78229, TX • Ph : 210.617.4311 • Fax: 210.617.4312
www.GalaxySpecialtyPharmacy.com

Date Medication Needed: _____ **Ship To:** Patient's Home Prescriber's office Pickup (store location): _____ Injection training by pharmacy?

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	Email	
SSN	Allergies	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Clinical Assessment

Please FAX recent clinical notes, labs and tests with the prescription to expedite the Prior Authorization process

Diagnosis (ICD-10) ☐ **E78.01** (Familial Hypercholesterolemia) **Type of Familial Hypercholesterolemia:** ☐ **HeFH** (Heterozygous) ☐ **HoFH** (Homozygous)
☐ **E78.0** (Pure Hypercholesterolemia) ☐ **E78.2** (Mixed Hyperlipidemia) ☐ **E78.4** (Other Hyperlipidemia) ☐ **E78.5** (Unspecified Hyperlipidemia)

For clinical ASCVD patients, please select the appropriate ICD code for hypercholesterolemia AND include the specific ASCVD diagnosis code.

ASCVD-Specific Code (ICD-10): _____

History of ASCVD Event: ☐ **None** ☐ **Yes (select all that apply):** ☐Unstable Angina ☐ Angina Pectoris ☐ Acute Myocardial Infarction
☐ Subsequent Myocardial Infarction ☐ Chronic Ischemic Heart Disease ☐ Cerebral Infarction ☐ Other Cerebrovascular Diseases
☐ Occlusion and stenosis of Cerebral Arteries, Intracranial ☐ Other: _____

Previous Lipid-Lowering Treatments:

☐ None ☐ Yes (Check all that apply)

	Strength/Freq	Dates of Therapy
☐ atorvastatin	_____mg/_____	mm/yy _____ to _____
☐ ezetimibe	_____mg/_____	mm/yy _____ to _____
☐ pravastatin	_____mg/_____	mm/yy _____ to _____
☐ rosuvastatin	_____mg/_____	mm/yy _____ to _____
☐ simvastatin	_____mg/_____	mm/yy _____ to _____
☐ Other: _____	_____mg/_____	mm/yy _____ to _____
☐ Other: _____	_____mg/_____	mm/yy _____ to _____

Other Lipid-Lowering Agents to be Used Concurrently with PCSK9 Treatment:

☐ None ☐ Yes (Please indicate below):

_____
_____
_____

Is the patient statin intolerant? ☐ Yes ☐No **If Yes, describe intolerance:** _____

Any other contraindications to non-PCSK9 therapy for hypercholesterolemia? _____

Lab Values: ☐ LDL-C _____ mg/dL Date: _____ **Drug Allergies:** _____

☐Sharps container and alcohol pads to be provided as needed ☐ Injection training needed

Additional Information/Special Instructions

Medication	Dose/Strength	Directions for Use	Quantity	Refills
☐ **Praluent®** ☐Pre-Filled **Pen**	☐ 75 mg/ml 2-Pack ☐ 150 mg/ml 2-Pack	☐ Inject 75 mg SQ every 2 weeks ☐ Inject 150 mg SQ every 2 weeks	28 days	
☐ **Repatha™** Pre-Filled **Syringe**	☐ 140 mg/ml 1-Pack (Syringe)	☐ Inject 140 mg SQ every 2 weeks (2 Syringes) ☐ Inject 420 mg SQ once monthly (3 Syringes)	28 days One month	
☐ **Repatha™ SureClick® Autoinjector**	☐ 140 mg/ml 2-Pack (Pen)	☐ Inject 140 mg SQ every 2 weeks	28 days	
☐ **Repatha™ Pushtronex™ System**	☐420mg/3.5ml single-use Pushtronex™ System	☐ Inject 420mg once monthly (over 9 minutes by using the single-use on-body infusor with pre-filled cartridge)	One month	

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)