BERGEN AVE DRUGS
Specialty Pharmacy

REPATHA PRESCRIPTION REFERRAL FORM

745 Bergen Ave | Jersey City, NJ, 07306
Tel 201.521.0545 | Fax 201.521.0546

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Last updated: May 2017

Patient Name _____ SS#_____ DOB _____ Height _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Evening Tel _____ Cell _____ ☐ Text Message Allowed Email _____

Caregiver Name _____ Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy

Allergies _____ Comorbidities _____

Current Medications (if necessary, please fax a complete list) _____

ICD-10 Diagnosis: ☐ E78.0 Pure Hypercholesterolemia ☐ E78.2 Mixed Hyperlipidemia ☐ E78.4 Other Hyperlipidemia ☐ E78.5 Hyperlipidemia, unspecified

Please add one **secondary** ICD-10-CM code: _____

Weight_____ Blood Pressure _____ Current smoker? ☐ Yes ☐ No LDL-C Value _____ mg/dL on date_____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn#_____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City_____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PREVIOUS OR CURRENT LIPID LOWERING TREATMENTS

☐ none

	Strength/Freq	*Dates of Therapy*
☐ Atorvastatin (Lipitor®)	_____mg/ _____	mm/yy _____ to _____
☐ Ezetimibe (Zetia®)	_____mg/ _____	mm/yy _____ to _____
☐ Pravastatin (Pravachol®)	_____mg/ _____	mm/yy _____ to _____
☐ Rosuvastatin (Crestor®)	_____mg/ _____	mm/yy _____ to _____
☐ Simvastatin (Zocor®)	_____mg/ _____	mm/yy _____ to _____
☐ Other_____	_____mg/ _____	mm/yy _____ to _____
☐ Other_____	_____mg/ _____	mm/yy _____ to _____

REPATHA® (evolocumab)

☐ 140 mg/ml single-use prefilled SureClick® autoinjector

SIG: Inject 140 mg subcutaneously every 2 weeks

QTY: ☐1 month supply

☐ 3 month supply

☐ Other _____

Refills _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

Please fax completed form to **Bergen** at **201.521.0546**

Visit us at **WWW.BERGENDRUGS.COM** for online fillable forms.