BROADWAY SPECIALTY PHARMACY

CARDIOLOGY

Fax: 833.803.3110
Phone: 800.640.8207
broadwayrx.health

1. PATIENT INFORMATION

****PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK and CLINICAL NOTES/LABS ****

NAME:		ADDRESS:		CITY:	STATE:	ZIP:
DOB:	SEX: ☐ F ☐ M	PHONE:	CELL PHONE:		SSN:	
HEIGHT:	WEIGHT:	HIPAA CONTACT/CAREGIVER:		ALLERGIES: ☐ LATEX ☐ NKDA		

2. CLINICAL INFORMATION

DATE OF DIAGNOSIS: _____ HISTORY: ☐ NEW ☐ RESTART ☐ CONTINUING

DIAGNOSIS / ICD-10:	SECONDARY ICD-10:	OTHER:
MOST RECENT LDL-C LEVEL ON TREATMENT: _____ DATE:_____		CURRENT THERAPY:

FAILED TREATMENTS: (MAX DOSE)	DATES / REASON CONTRAINDICATED (CI), INAQAQUATE RESPONSE (IR), NOT TOLERATED (NT), OTHER	FAILED TREATMENTS:	DATES / REASON CONTRAINDICATED (CI), INAQAQUATE RESPONSE (IR), NOT TOLERATED (NT), OTHER
ATORVASTATIN (_____)		EZETIMIBE	
LOVASTATIN (_____)		FIBRATES	
PRAVASTATIN (_____)		NIACIN	
ROSUVASTATIN (_____)		OMEGA-3	
SIMVASTATIN (_____)		OTHER: _____	

3. Rx

IF SHIPPING TO PRESCRIBER: NEXT APPT DATE: _____ ☐ FIRST FILL ☐ ALL FILLS | **PATIENT RECEIVED STARTER DOSE:** ☐ YES: DATE _____ ☐ NO

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ PRALUENT®	o 75mg/ml Prefilled Pen 2 Pack o 150mg/ml Prefilled Pen 2 Pack	o Inject 75mg Sub-Q every 2 weeks o Inject 150mg Sub-Q every 2 weeks o Inject 300mg(2 x 150mg) Sub-Q once a month	2	_____
☐ REPATHA®	o 140mg/ml SureClick o 420mg/3.5ml Pushtronex	o Inject 140mg Sub-Q every 2 weeks o Inject 420mg (3 x 140mg) Sub-Q once a month o Administer Sub-Q every month using Pushtronex system on-body with prefilled cartridge	2 3 1 Pack	_____
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☐				
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4. PRESCRIBER INFORMATION

UPON PA DENIAL: ☐ SEND FORMULARY ALTERNATIVES ☐ DRAFT APPEAL | INJECTION TRAINING: ☐ PHARMACY TRAIN/ADMINISTER ☐ PRESCRIBER

PRESCRIBER SIGNATURE:

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing Broadway Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-Pay Assistance/Foundations.

Signature: _____ Date:_____ Signature:_____ Date: _____

Substitution Permitted — Dispense As Written

PRESCRIBER NAME:	ADDRESS:		CITY:	STATE:	ZIP:
OFFICE CONTACT:	PHONE:	FAX:	NPI:	DEA:	