FAX 1-844-504-3278
PHONE 1-877-327-8881
www.FASTACCESSRX.com

# ENDOCRINOLOGY FORM

**PATIENT INFORMATION:**

Patient Name:______________________________________
Date of Birth:_____________Male: ☐ Female: ☐
Address:__________________________________________
City/State/Zip:______________________________________
Tel:______________________Alt Tel:__________________
SS#:______________________Wt:_________Ht:_________
NKDA: ☐ Allergy:________________________________

**INSURANCE INFORMATION:**

Primary Pharmacy Insurance_________________________
Member Name:____________________________________
Member ID:______________________________________
Rx Group #:_______________________________________
BIN#________________PCN#_______________________
Customer Service #:_______________________________
***Please attach a copy of the front and back of the patient's insurance card, if available.******

**DIAGNOSIS AND CLINICAL INFORMATION:**

ICD10 code: ☐ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH) ☐ E78.2 Mixed Hyperlipidemia
☐ E78.4 Other and Unspecified Hyperlipidemia ☐ Other:_____________________________________________
Prior meds failed:________________________________________________________________________
LDL-C Treatment - ☐ Atorvastatin ☐ Rosuvastatin ☐ Simvastatin ☐ Ezetimibe ☐ Other_______________Dose:____
Other pertinent medical history or drug therapy:_______________________________________________
☐ Forteo® Home Health Training Required

**PRESCRIBER INFORMATION:**

Prescriber Name:_________________________________Specialty:______________________________
Address:_______________________________________City/State/Zip:__________________________
Contact Name:____________________Phone #:____________________________Fax #:___________________
NPI#:__________________________DEA #:_____________________________UPIN #:__________________

By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Printed Name:___________________________________________Date:_____________________
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_______________________________________ _______________________________________
*Substitution Allowed* *Dispense as Written*

**PRESCRIPTION:**

| Medication | Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| ☐ Forteo® | 600mcg/2.4ml | Inject 20mcg subq daily | 1 month | ______ |
| ☐ Praluent® | ☐ 75mg PFS<br>☐ 75mg Pen<br>☐ 150mg PFS<br>☐ 150mg Pen | ☐ Inject 75mg SubQ once every 2 weeks<br>☐ Inject 150mg SubQ once every 2 weeks | 1 month | ______ |
| ☐ Prolia® | 60mg | Inject 60mg subq every 6 months | 1 month | ______ |
| ☐ Reclast® | 5mg/100ml | Infuse 5mg once yearly | 1 vial | ______ |
| ☐ Repatha® | 140mg/ml Sureclick | ☐ Inject 140mg every 2 weeks into abdomen, thigh or upper arm<br>☐ Inject 420mg once monthly in abdomen, thigh, or upper arm (Give 3 injections within 30 minutes) | 1 month | ______ |
| ☐ Thyrogen | 2 vial kit | Inject 0.9mg IM day 1 followed by 0.9mg IM day 2 | 1 kit | ______ |
| ☐ Other | __________ | ______________________________________________ _ | ________ | ______ |