FACTOR ONE SOURCE FAST PHARMACY

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

CARDIOLOGY 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:

Diagnosis and ICD10: ☐ I50.20 Systolic Heart Failure unspecified ☐ I50.22 Systolic Heart Failure Chronic ☐ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH) ☐ E78.2 Mixed Hyperlipidemia ☐ E78.4 Other and Unspecified Hyperlipidemia
☐ I25.10 Atherosclerotic Cardiovascular Disease ☐ Other:_____
Prior meds failed: _____
Beta Blockers - ☐ Carvedilol ☐ Metoprolol succinate ☐ Other:_____Beta-blocker dose:_____
Stable at Maximum Tolerated Dose: ☐ Yes ☐ No
Not on beta-blocker due to : ☐ beta-blocker intolerance ☐ beta-blocker contraindication
ACEs - ☐ Lisinopril ☐ Enalapril ☐ Ramipril ☐ Other:_____
ARBs - ☐ Losartan ☐ Valsartan ☐ Other:_____
Resting Heart Rate: ☐ > 70 BPM or enter rate:_____ In Sinus Rhythm ☐ Yes ☐ No NYHA Class ☐ II ☐ III ☐ IV
Left Ventricular Ejection Fraction ≤ 35%?: ☐ Yes_____
LDL-C Treatment - ☐ Atorvastatin ☐ Rosuvastatin ☐ Simvastatin ☐ Ezetimibe ☐ Other_____Dose:_____
Other pertinent Medical History or Drug Therapy:_____
_____

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
DATE:_____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 Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

Medication	Strength	Directions	Quantity	Refills
☐ Praluent®	☐ 75mg Pen ☐ 75mg PFS ☐ 150mg Pen ☐ 150mg PFS	☐ Inject 75mg SubQ every 2 weeks ☐ Inejct 150mg SubQ every 2 weeks	1 month supply	_____
☐ Repatha®	☐ 140mg/mL SureClick® ☐ 420 mg/3.5 mL single-use Pushtronex™ System	☐ Inject 140-mg/mL subcutaneously using a SureClick® autoinjector every two (2) weeks ☐ Administer 420-mg/3.5 mL subcutaneously using a Pushtronex™ system (on body infusor with prefilled cartridge) once (1) monthly	1 month supply	_____
☐ Zontivity®	☐ 2.08mg	☐ Take 1 tablet by mouth once daily	1 month supply	_____
☐ Other _____	_____	_____	supply	_____