

Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:
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The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Name (last, first) _____ DOB: _____

ALL OF THE FOLLOWING INFORMATION IS REQUIRED :

Primary DX:

- E78.00 Pure hypercholesterolemia, unspecified
- E78.2 Mixed hyperlipidemia
- E78.4 Other hyperlipidemia
- E78.49 Other hyperlipidemia, familial combined
- E78.5 Hyperlipidemia, unspecified
- E78.01 Familial hypercholesterolemia
- E75.5 Other lipid storage disorders
- E78.011 Heterozygous familial hypercholesterolemia (HeFH)

Secondary DX is required:

- I25.10 ASCVD native CA w/o angina pectoris
- I25.110 ASCVD Native CA w/angina pectoris
- I25.111 ASCVD native CA w/angina w/spasm
- I25.118 ASCVD native CA w/other forms of angina
- I25.119 ASCVD native CA w/unspecified angina
- OTHER: _____

If patient has a history of clinical atherosclerotic cardiovascular disease (ASCVD)—select all that apply:

- Angina, stable or unstable
- Coronary syndrome, acute
- Myocardial infarction, history of Revascularization, coronary or other arterial (coronary artery bypass grafting, percutaneous transluminal coronary angioplasty, etc)
- Peripheral arterial disease
- Positive findings in computed tomography angio or cath
- Stroke
- Transient ischemic attack
- Other: _____

If patient has an increased risk of ASCVD—select all that apply:

- Age ≥65 years
- History of prior coronary artery bypass surgery or PCI outside of the major ASCVD event(s)
- Diabetes mellitus
- Hypertension
- Chronic kidney disease (eGFR 15-59 mL/min/1.73 m²)
- Current smoking
- Persistently elevated LDL-C (≥100 mg/dL [≥2.6 mmol/L]) despite maximally tolerated statin therapy and ezetimibe
- History of congestive heart failure
- Other: _____

If patient has a history of HeFH—select all that apply

- Dutch Lipid/WHO Score >8
- Pretreatment LDL-C ≥190 mg/dL
- First or second degree relative with pretreatment LDL-C ≥190 mg/dL
- Simon Broome diagnostic criteria met
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- Other: _____

Lab Values

Relevant tests and recent lab values including LDL-C levels >70 mg/dL

Current and previous lipid-lowering therapy—select all that apply

- Atorvastatin (LIPITOR®) 10 20 40 80 Dates/length of use: _____
- Pravastatin (PRAVACHOL®) 10 20 40 80 Dates/length of use: _____
- Simvastatin (ZOCOR®) 5 10 20 40 80 Dates/length of use: _____
- Rosuvastatin (CRESTOR®) 5 10 20 40 Dates/length of use: _____
- Ezetimibe (ZETIA®) 10 Dates/length of use: _____
- Other: _____ Dates/length of use: _____
- Patient not at recommended target despite lipid-lowering therapy

Medical history for statin therapy—select all that apply

- Patient experienced myalgia/myositis that resolved when removed from therapy
- Patient has undergone re-challenge with lower dose statin with symptom reappearance
- Patient has known contraindications to statins
- Patient has creatine phosphokinase elevations >10x upper normal limit
- Other: _____

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. **** NOTE **** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
 - *Include recent chart notes, all relevant scans, tests and lab results*
 - **OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS**
 - *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
 - Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
 - *-Please notify our office if medication will be discontinued.*
- Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: _____