



TODT HILL PHARMACY

SPECIALTY PHARMACY

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CARDIOVASCULAR

ENROLLMENT FORM

Prescribing Practitioner:		NPI:
Supervising Physician:		NPI:
Address:		Tax ID:
Office:	Fax:	
Contact:		

PATIENT INFORMATION

Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB: ___/___/___	SS#:
Tel:	Alt Tel:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Wt.: ___ Ht.: ___
Street:	City:	State:	ZIP:

PRESCRIPTION

New Refill Ship by: ___/___/___ SHIP TO: Patient's Home Doctor's Office Other: _____

DRUG	STRENGTH	DIRECTIONS & QUANTITY	REFILLS
REPATHA	<input type="checkbox"/> SURECLICK AUTOINJECTOR	<input type="checkbox"/> INJECT 140 mg SQ EVERY 2 WEEKS (QUANTITY: 2)	
	<input type="checkbox"/> PRE-FILLED SYRINGE	<input type="checkbox"/> INJECT 140 mg SQ EVERY 2 WEEKS (QUANTITY: 2) <input type="checkbox"/> INJECT 420 mg SQ ONCE MONTHLY (QUANTITY: 3) *TO ADMINISTER 420 mg, GIVE 3 INJECTIONS CONSECUTIVELY WITHIN 30 MINUTES*	
	<input type="checkbox"/> PUSHTRONEX SYSTEM	<input type="checkbox"/> ADMINISTER 420 mg SQ ONCE MONTHLY OVER 9 MINUTES BY USING THE SINGLE-USE ON-BODY INFUSOR WITH PREFILLED CARTRIDGE (QUANTITY: 1)	
PRALUENT	<input type="checkbox"/> PRE-FILLED PEN	<input type="checkbox"/> INJECT 75 mg SQ EVERY 2 WEEKS (QUANTITY: 2) <input type="checkbox"/> INJECT 150 mg SQ EVERY 2 WEEKS (QUANTITY: 2) <input type="checkbox"/> INJECT 300 mg SQ EVERY 4 WEEKS (QUANTITY: 2) *TO ADMINISTER 300 mg, GIVE TWO 150 mg INJECTIONS CONSECUTIVELY AT TWO DIFFERENT INJECTION SITES*	
	<input type="checkbox"/> 75 mf/ml <input type="checkbox"/> 150 mg/ml		

MEDICAL INFORMATION

*** PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY***

PREVIOUS THERAPIES	TRIED & FAIKED (DURATION)	NOT TOLERATED	CONTRAINDICATION
<input type="checkbox"/> LIPITOR (ATORVASTOTIN CALCIUM)	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> CRESTOR (ROSUVASTATIN CALCIUM)	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> ZOCOR (SIMVASTATIN)	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> LIVALO (PITAVASTATIN)	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> PRAVACHOL (PRAVASTATIN SODIUM)	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> ZETIA (EZETIMIBE)	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> VYTORIN (EZETIMIBE/SIMVASTATIN)	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	_____

INDICATE ONE PRIMARY DIAGNOSES

- E78.0 HEFH PURE HYPERCHOLLESTEROLEMIA
- E78.0 HOFH PURE HYPERCHOLLESTEROLEMIA
- E78.2 HOFH MIXED HYPERLOPIDEMIA
- E78.4 OTHER HYPERLIPIDEMIA
- E78.5 HYPERLIPIDEMIA, UNSPECIFIED
- OTHER

INDICATE ALL APPLICABLE DIAGNOSES

- 120.0 UNSTABLE ANGINA
- 120.9 ANGINA PECTORIS, UNSPECIFIED
- 121. ___ ACUTE MYOCARDIAL INFARCTION
- 125. ___ OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
- 125.10 ASCVD, UNSPECIFIED
- 163.9 CEREBRAL INFARCTION, UNSPECIFIED (CVA)
- 165.3 OCCLUSION AND STENOSIS OF BILATERAL CAROTID ARTERIES
- 167.9 CEREBROVASCULAR DISEASE, UNSPECIFIED
- 170. ___ ATHEROSCLEROSIS
- 173.9 PERIPHERAL ARTERY/VASCULAR DISEASE, PAD/PVD
- G45.9 TRANSIENT CEREBRAL ISCHEMIC ATTACK (TIA)
- OTHER _____

PLEASE ATTACH A COPY OF THE MOST RECENT LIPID PANEL

ALLERGIES: _____ EXPECTED DURATION OF THERAPY 8 WEEKS 12 WEEKS 16 WEEKS 24 WEEKS

ADDITIONAL CLINICAL INFORMATION:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing TODT Hill Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations

Prescribing Practitioner: _____

Date: _____/_____/_____

CONFIDENTIALITY NOTICE

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