CEDRA

CARDIOLOGY
REFERRAL FORM

FAX: 888.889.7129
TOLL FREE: 844.233.7279
CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone:

SSN#: Language: ☐ English ☐ Other

Address: Sex: ☐ Male ☐ Female Height: Weight: ☐ lbs ☐ kg

City: State: Zip: Known Allergies:

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#:

Address: Phone: E-mail:

City: State: Zip: Key Contact: Phone: Fax:

STATUS UPDATE PREFERENCE: ☐ Phone ☐ Text ☐ Fax ☐ E-mail:

DIAGNOSIS/CLINICAL INFORMATION

STATINS:	Tried & Failed (Duration)	Not Tolerated	Contraindication:
☐ Simvastatin	☐ ( )	☐	
☐ Atorvastatin	☐ ( )	☐	
☐	☐ ( )	☐	

Other therapies:	Tried & Failed (Duration)	Not Tolerated	Contraindication:
☐ Zetia	☐ ( )	☐	
☐ LDL Apheresis	☐ ( )	☐	
☐	☐ ( )	☐	

Allergies:

Date of Diagnosis:

Indicate One Primary Diagnosis:
- ☐ E78.0 Pure Hypercholesterolemia (HeFH and HoFH)
- ☐ E78.2 Mixed Hyperlipidemia
- ☐ E78.5 Other and Unspecified Hyperlipidemia
- ☐ Other:

Indicate One Secondary Diagnosis:
- ☐ 121. Acute Myocardial Infarction
- ☐ 125.2 Old Myocardial Infarction
- ☐ 125. Other Forms of Chronic Ischemic Heart Disease
- ☐ 125.10 ASCVD, Unspecified
- ☐ 165. Occlusion and Stenosis of Precerebral Arteries
- Other:
- ☐ 16 . Occlusion of Cerebral Arteries (CVA)
- ☐ G45. Transient Cerebral Ischemia (TIA)
- ☐ I67. Other and Ill-Defined Cerebrovascular Disease
- ☐ 169. History of Stroke with Residuals
- ☐ 170. Atherosclerosis
- ☐ 173.9 Peripheral Vascular Disease, Unspecified

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
☐ BRILINTA®	☐ 60 mg tablet ☐ 90 mg tablet	☐ Initiate treatment with 180 mg oral loading dose following an ACS event. ☐ Continue treatment with 90 mg twice dailyduring the first year after an ACS event. ☐ After one year, administer 60 mg twicedaily. Use BRILINTA with a daily maintenance dose of aspirin of 75-100 mg.		
☐ CRESTOR®	☐ mg tablets	☐ Take 1 tablet by mouth with or without food daily.		
☐ EFFIENT®	☐ 5 mg tablet ☐ 10 mg tablet	☐ Initial treatment single 60-mg oral loading dose ☐ Continue at 10 mg once daily with or without food. ☐ Consider 5 mg once daily for patients <60 kg.		
☐ ENTRESTO®	☐ 24 mg/26 mg tablet ☐ 49 mg/51 mg tablet ☐ 97 mg/103 mg tablet	☐ 1 tablet twice daily		
☐ JARDIANCE®	☐ 10 mg tablet ☐ 25 mg tablet	☐ Taken once daily in the morning with or without food	30 day supply	
☐ LIPITOR®	☐ mg tablets	☐ Take 1 tablet by mouth daily.		
☐ LIVALO®	☐ 1 mg tablet ☐ 2 mg tablet ☐ 4 mg tablet	☐ Starting dose 2 mg; may be increased to 4 mg per day. ☐ Moderate and severe renal impairment; starting does of 1 mg once daily and maximum of 2 mg once daily.		
☐ LOVAZA®	☐ 1 gram capsule	☐ Four (4) capsules once daily ☐ Two (2) capsules twice per day		
☐ PRADAXA®	☐ 75 mg capsule ☐ 110 mg capsule ☐ 150 mg capsule	**Non-valvular Atrial Fibrillation:** ☐ CrCl >30 mL/min: 150 mg orally, twice daily ☐ CrCl 15-30 mL/min: 75 mg orally, twice daily **Treatment of DVT and PE:** ☐ CrCl >30 mL/min: 150 mg orally, twice daily after 5-10 days of parenteral anticoagulation **Reduction in the Risk of Recurrence of DVT and PE:** ☐ CrCl >30 mL/min: 150 mg orally, twice daily after previous treatment **Prophylaxis of DVT and PE Following Hip Replacement Surgery:** ☐ CrCl >30 mL/min: 110 mg orally first day, then 220 mg once daily		
☐ PRALUENT®	☐ Prefilled Pens	☐ Inject 75 mg SC every 2 weeks (quantity: 2). ☐ Inject 150 mg SC every 2 weeks (quantity: 2).		
☐ REPATHA®	☐ Prefilled Pens ☐ Prefilled SureClick Autoinjector	☐ Option 1: Inject 140 mg SC in the abdomen, thigh, or upper arm every 2 weeks (quantity 2). ☐ Option 2 (recommended for HOFH): Inject 420 mg (3 syringes) SC in the abdomen, thigh, or upper arm once monthly. Administer 3 consecutive injections within 30 minutes (quantity 3).		
☐ VASCEPA®	☐ 1 gram capsule	☐ Four (4) capsules once daily ☐ Two (2) capsules twice per day		
☐ ZETIA®	☐ 10 mg tablet	☐ One tablet daily with or without food		
☐				

Date Medication Needed: Deliver To: ☐ Patient Home ☐ MD Office

Prescriber Signature: (Please sign and date below.)

Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible Date Dispense as written "DAW" Date

SUBMIT FORM CLEAR FORM