TFP WELLNESS SYSTEMS

Your Lifetime Pharmacy Solution

CARDIOVASCULAR
ENROLLMENT FORM

Phone: 813-868-4799 Fax: 813-877-2479

PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	☐ NKDA
Date of Birth	SSN#	Weight _____ ☐ kg ☐ lb date	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address(optional)	

INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF MEDICAL AND PRESCRIPTION CARDS, IF AVAILABLE)

Primary Insurance		Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

DIAGNOSIS/MEDICAL INFORMATION (COMPLETE CLINICAL INFO BELOW OR ATTACH PATIENTS LABS)

☐ E78.0 Pure Hypercholesterolemia
☐ E78.5 Unspecified Hyperlipidemia
☐ E78.2 Mixed Hyperlipidemia
☐ E78.4 Other Hyperlipidemia
☐ ASCVD Specific Code:_____

Please provide one secondary ICD-10-CM code: ☐Other (specify ICD-10-CM):_____

☐ I20.0 Unstable Angina ☐ I20.9 Angina Pectoris, Unspecified ☐ I21.___ Acute Myocardial Infarction ☐ I22._____ Subsequent Myocardial Infarction
☐ I25._____ Chronic Ischemic Heart Disease ☐ I63._____ Cerebral Infarction ☐ I65._____ Occlusion and Stenosis of Cerebral Arteries, Extracranial
☐ I66._____ Occlusion and Stenosis of Cerebral Arteries, Intracranial ☐ I67._____ Other Cerebrovascular Diseases ☐ I70._____Atherosclerosis
☐I73.9 Peripheral Vascular Disease, Unspecified ☐G45.9 Transient Cerebral Ischemic Attack, Unspecified ☐G46._____ Vascular Syndromes

LDL–C on Treatment: _____ Date: _____ Family History of ACSVD ☐ Yes ☐ No

Prior and/or Current Treatments: ☐ Atorvastatin (Lipitor®) ☐ Ezetimibe (Zetia®) ☐ Pravastatin (Pravachol®)
☐ Rosuvastatin (Crestor®) ☐Simvastatin (Zocor®) ☐ Other _____ Dose_____

Length of Treatment_____ Reason for Discontinuing _____

PRESCRIPTION INFORMATION

Medication	Strength/Dose	Directions	Quantity	Refills
☐ Corlanor ™ ☐ Eliquis ™ ☐ Entresto ™ ☐ Pradaxa ™ ☐ Xarelto ™		☐ Sig: _____ _____	☐ 30 ☐ 60 ☐ 90 ☐ _____	
Praluent™	☐ 75 mg/mL Pre filled Pen 2 pack ☐ 150mg/mL Prefilled Pen 2 pack	☐ Inject subcutaneously once every 2 weeks ☐ Inject 300 mg (two 150 mg pens) subcutaneously once every 4 weeks into two different injection sites	4 week supply	
Repatha™	☐ 140 mg/mL SureClick® 2 pack ☐ 420 mg/3.5 mL single-use Pushtronex™	☐ Inject subcutaneously once every 2 weeks ☐ Inject subcutaneously once monthly	4 week supply	
Enoxaparin	☐ 30mg/0.3mL ☐ 40mg/0.4mL ☐ 60mg/0.6mL ☐ 80mg/0.8mL ☐ 100mg/1.0mL ☐ 120mg/0.8mL ☐ Other: _____	☐ Sig: _____ _____		

DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ 1st dose to MD's office, remaining refills to patient's home
☐ Patient's Home

Date Medication Needed:
Pharmacy to coordinate injection training with HH nurse:
☐ YES ☐ NO

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name:	Office Contact:	Institution:
Phone:	Fax:	Specialty: **Cardiology**
Address:		City, State, Zip:
License #	Tax ID:	NPI #

Physician's Signature _____ **Date** _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.