Statin Therapy Protocol Screening Qu	iestionnaire Pa	tient Name:		_ Patient DOB:
P	atient to complete	pages 1 and 2	2	
Patient Information:				
(Patient to complete)				
Today's Date:				
Patient Name:		Patient DOB	:	Patient Age:
Patient Contact Number:		Patient Address:		
Primary Care Provider:				
Primary Care Provider Number: () -			
Do you have health insurance?		If yes, please list Health Insurance Plan:		surance Plan:
☐ Yes				
□ No				
Medical History (Patient to complete)				
Please check any medical problems	or health conditions	you have:		
☐ History of heart attack	☐ History of blo	cked arteries	☐ Diabetes	
☐ High blood pressure	☐ Chest pains		☐ Other,	please list below
Please list any <i>additional</i> medical p				
Allergies (Patient to complete)				
nedications?	If yes, please list allei	rgies / sensitivi	ities here:	
☐ Yes				
□ No				

Patient, continue to next page

	dications tient to complete)						
Are	you taking any medica	tions currently (in	ncluding OTC/herbal/vita Yes No	mins/supp	lements)?		
If ye	es, please list medicatio	ons (including OT	CC/herbal/vitamins/supple	ements) he	re:		
N	ame of Medication	Strength	Directions		Indication / Reason		
Speci	fic Medical History:						
(Patie	ent to complete)						
1	Are you under 20 years	s of age?		☐ Yes	☐ No	☐ Unsure	
2	Are you a woman of childbearing potential?		☐ Yes	□ No	☐ Unsure		
3	Have you ever had a bad reaction to any cholesterol medications?			☐ Yes	□ No	☐ Unsure	
4	Do you have any known medical problems with your liver?			☐ Yes	□ No	☐ Unsure	
5	Do you have any known medical problems with your kidneys, or are you undergoing any type of dialysis?		☐ Yes	□ No	☐ Unsure		
6	Have you ever been told you have high triglycerides?		☐ Yes	□ No	☐ Unsure		

Statin Therapy Protocol Screening Questionnaire

Thank you for completing the patient portion of this questionnaire.

Patient Name: Patient DOB: ____

Stati	in Therapy Protocol Screening Questionnaire Patient Name:	Patient [ЮВ:
eci	Internal use only-Pharmacist to Complete fic Medical History Review-Corresponding detailed follow up:		
evie	w Patient responses and verify patient eligibility using the following criteria:		
1	Is the patient under 20 years of age?	☐ Yes	□ No
2	Are you a woman of childbearing potential and currently using an effective form of birth control?	☐ Yes	□ No
3	Does the patient have, or has ever had, serious statin-associated side effects? (examples include a serum creatinine kinase elevation > three times the upper limit of normal, documented muscle pain (rhabdomyolysis) from statin therapy, or hepatic transaminase elevations 3 times the upper limit of normal during prior treatment with statin therapy.)	☐ Yes	□ No
4	Does the patient have active liver disease defined by medical history or by hepatic transaminases greater than 3 times the upper limit of normal?	☐ Yes	☐ No
5	Does the patient have end stage renal disease (ESRD) or is the patient undergoing hemodialysis or peritoneal dialysis?	☐ Yes	□ No
6	Does the patient have severe hypertriglyceridemia (fasting triglycerides > 1000 mg/dL)?	☐ Yes	□ No
ote	s Section for above review:		
Eligi	bility Criteria:		
1	High-Risk primary prevention		
a.	10-year ASCVD risk > 20% using the American College of Cardiology risk calculator (found at https://tools.acc.org/ascvd-risk-estimator-plus/#!/calculate/estimate/) age 40-75 OR	☐ Yes	□ No
b.	LDL ≥ 190 mg/dL tested using a fasting lipid panel, age 20-75	☐ Yes	□ No
2	Primary prevention patients with diabetes mellitus		
a.	Type 2 diabetes mellitus (DM) age 40-75 as determined by patient report,	☐ Yes	□ No

3

a.

medical records, or prescription history

report, medical records, or prescription history.

Prior history of: acute myocardial infarction, acute coronary syndrome, stable

or unstable angina, coronary or arterial revascularization by coronary artery bypass graft (CABG) surgery and / or stenting, non-cardioembolic ischemic stroke, transient ischemic attack, aortic aneurysm, or peripheral artery disease all stemming from atherosclerotic origins, as confirmed by patient

Secondary prevention

☐ Yes

☐ No

Patient Name:	Patient DOB:
raticiit ivailie.	raticiit DOD.

Internal use only-Pharmacist to Complete

<u>Docum</u>	entation	•		
	Verified patient DOB (with valid Colorado photo ID)			
	Patient Not Eligible (Due to Medical History Line Item # a OR (Prior history of			
	Medication Prescribed per Protocol			
Routine	e Required monitoring:			
	Required Fasting Lipid Panel (FLP) @ E	Baseline		
Pharma	Acist Consultation Medication Adherence: Importance in relation to e What to do if patient misse		nd reduction in CV event risk	
	Therapeutic Lifestyle changes Importance in reducing lipi	ds and CV risk		
	Medication Counseling Provided Potential medication interactions Potential food interactions Signs & Symptoms of myalg common)		astatin and simvastatin) educate that side effects are not	
	Follow-up Necessity of patient to follo Usual care and lipid testing		eam as soon as possible Pharmacy	
(Refer t	acist Communication to PCP- to SBOP Rules 17.00.50(a)) Care Provider notified of: Medication Prescribed Labs	Medication Prescribed: Drug: Sig:	Pharmacy address Pharmacy Phone Strength:	
0	☐ Care Plan	Qty: Pharmacist Prescriber Name	Refill Qy: :	
	nt isn't followed by a PCP, patient was p Above action plan (Medication P List of providers/clinics for which	rescribed, Labs and Care	plan)	

Statin Therapy Protocol Screening Questionnaire	Patient Name:	Patient DOB:
Internal use only-Ph	narmacist to Complete	
Follow-up Plan:		
☐ Required-Fasting Lipid Panel (FLP) @ 4-12 weeks	safter therapy initiation Date:_	
Schedule time to assess patient medication tole	rance / side effects / adherence	Date:
Based on patient follow up:		
Patient referred to Primary Care Provider Referral for:		
☐ Prior history of statin use with noted into	olerance	
 On therapy, if patient experiences mode not resolve with stopping medication 	rate to severe statin associated r	nuscle symptoms that do
 On therapy, if patient experiences sympt (dark brown urine with severe muscle sy 		• •
On therapy, if patient develops symptom yellow-colored eyes or skin)-patient show	ns suggestive of liver disease (sev	
☐ Suboptimal response to maximum tolera	•	nues statin and referred
for further workup	ted statill therapy patient contin	ides statiii and referred
Other		
Additional Notes:		

Attention Pharmacy: This is a template document. Please feel free to customize it to your particular company, however you <u>must retain all elements</u> set forth by this template.

Pharmacist Name: ______

Pharmacist Signature:

Date: _____