Patient to complete pages 1 and 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? ☐ Yes ☐ No	If yes, please list Health Insurance Plan:	

Medical History

(Patient to complete)

Please check any medical problems or health conditions you have:

☐ History of heart attack	☐ History of blocked arteries	☐ Diabetes
☐ High blood pressure	☐ Chest pains	☐ Other, please list below

Please list any ***additional*** medical problems or health conditions:

_____

_____

_____

Allergies

(Patient to complete)

Allergies or sensitivities to medications? ☐ Yes ☐ No	If yes, please list allergies / sensitivities here: _____ _____

Patient, continue to next page

Medications

(Patient to complete)

Are you taking any medications currently (including OTC/herbal/vitamins/supplements)?

☐ Yes

☑ No

If yes, please list medications (including OTC/herbal/vitamins/supplements) here:

Name of Medication	Strength	Directions	Indication / Reason

Specific Medical History:

(Patient to complete)

1	Are you under 20 years 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

Thank you for completing the patient portion of this questionnaire.

Internal use only-Pharmacist to Complete

Specific Medical History Review-Corresponding detailed follow up:

Review 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

Notes Section for above review:

Eligibility 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, medical records, or prescription history	☐ Yes	☐ No
3	**Secondary prevention**		
a.	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 report, medical records, or prescription history.	☐ Yes	☐ No

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Documentation

☐ Verified patient DOB (with valid Colorado photo ID)

☐ Patient Not Eligible
(Due to Medical History Line Item # above _____)
OR
(Prior history of _____)

☐ Medication Prescribed per Protocol

Routine Required monitoring:

☐ Required Fasting Lipid Panel (FLP) @ Baseline _____

Pharmacist Consultation

☐ Medication Adherence:
- ☐ Importance in relation to efficacy of statin therapy and reduction in CV event risk
- ☐ What to do if patient misses a dose

☐ Therapeutic Lifestyle changes
- ☐ Importance in reducing lipids and CV risk

☐ Medication Counseling Provided
- ☐ Potential medication interactions (primarily with lovastatin and simvastatin)
- ☐ Potential food interactions
- ☐ Signs & Symptoms of myalgia and liver dysfunction (educate that side effects are not common)

☐ Follow-up
- ☐ Necessity of patient to follow up with primary care team as soon as possible
- ☐ Usual care and lipid testing at least yearly

Pharmacist Communication to PCP-
(Refer to SBOP Rules 17.00.50(a))
Primary Care Provider notified of :
- ☐ Medication Prescribed
- ☐ Labs
- ☐ Care Plan

OR

RX# Pharmacy
name
Pharmacy address
Pharmacy Phone
Medication Prescribed:
Drug: Strength:
Sig:
Qty: Refill Qy:
Pharmacist Prescriber Name:

If patient isn't followed by a PCP, **patient was provided**:
- ☐ Above action plan (Medication Prescribed, Labs and Care plan)
- ☐ List of providers/clinics for which to seek ongoing care

Internal use only-Pharmacist to Complete

Follow-up Plan:

- ☐ Required-Fasting Lipid Panel (FLP) @ 4-12 weeks after therapy initiation Date:_____
- ☐ Schedule time to assess patient medication tolerance / side effects / adherence Date:_____

Based on patient follow up:
Patient referred to Primary Care Provider Referral for:

- ☐ Prior history of statin use with noted intolerance
- ☐ On therapy, if patient experiences moderate to severe statin associated muscle symptoms that do not resolve with stopping medication
- ☐ On therapy, if patient experiences symptoms consistent with muscle weakness or rhabdomyolysis (dark brown urine with severe muscle symptoms) - patient should stop statin and be referred
- ☐ On therapy, if patient develops symptoms suggestive of liver disease (severe abdominal pain, yellow-colored eyes or skin)-patient should stop statin and be referred
- ☐ Suboptimal response to maximum tolerated statin therapy-patient continues statin and referred for further workup
- ☐ Other _____

Additional Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacist Name: _____

Pharmacist Signature:_____

Date: _____

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