Hypercholesterolemia Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

LIPRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ E78.01 Familial Hypercholesterolemia
Type: ☐ HeFH (Heterozygous) ☐ HoFH (Homozygous)
☐ E78.0 Pure Hypercholesterolemia
☐ E78.2 Mixed Hyperlipidemia
☐ E78.4 Other Hyperlipidemia
☐ E78.5 Unspecified Hyperlipidemia

Please list previously tried/failed therapies & dates:
Should be on maximally tolerated statin therapy

Current LDL-C Value: _____
Date of test: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Praluent®** (alirocumab)	☐ 75 mg/mL prefilled pen ☐ 150 mg/mL prefilled pen	☐ Inject 75 mg subcutaneously every 2 weeks ☐ Inject 150 mg subcutaneously every 2 weeks ☐ Inject 300 mg (two 150 mg injections) subcutaneously every 4 weeks		
☐ **Repatha®** (evolocumab)	☐ 140 mg/mL prefilled syringe ☐ 140 mg/mL SureClick® autoinjector	☐ Inject 140 mg subcutaneously every 2 weeks ☐ Inject 420 mg subcutaneously once monthly (three 140 mg injections consecutively within 30 minutes)		
	☐ 420 mg/3.5 mL single-use Pushtronex™ system	☐ Inject 420 mg subcutaneously once monthly (over 9 minutes by using the on-body infusor)		

Injection Training
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____