Hypercholesterolemia

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name:_____ DOB:_____ Gender: M ◯ F ◯

Address: _____ City:_____ State:_____ Zip: _____
Phone: _____ Alt. Phone: _____ Caregiver: _____
Email: _____ Height: _____ Weight:_____
Allergies: ◯ No Known ◯ See Attached Charts ◯ Other: _____

Please include front and back copies of insurance card.

Prescriber Information

Name: _____ NPI: _____
Address: _____ City: _____ State:_____ Zip:_____
Phone:_____ Fax: _____ Office Contact:_____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____
Primary ICD-10: _____
Secondary ICD-10: _____
Other: _____

Contraindications:
◯ Fibrates ◯ Statin ◯ Niacin

Reason for contraindication:
◯ Myopathy or Rhabdomyolysis ◯ Hepatic Disease ◯ Renal Dysfunction
◯ Pregnancy or Lactation ◯ Recent Stroke or TIA ◯ Other: _____

Prior Failed Therapies	Drug Name & Length of Treatment
☐ Fibrates	
☐ Niacin	
◯ Omega-3	
☐ Statin	
☐ Zetia	
☐ Other	

Laboratory Tests:

◯ Lipid Panel	◯ No	◯ Yes	Date:
◯ Liver Function	◯ No	◯ Yes	Date:
◯ Renal Function	◯ No	◯ Yes	Date:

Injection Training:
◯ Patient Trained in MD Office
◯ Manufacturer Nurse Support
◯ Pharmacist to Provide Training

Product Delivery:
◯ Pharmacy to Coordinate
◯ Physician's Office
◯ Patient's Home

If labs must be obtained from another prescriber, please indicate name here:_____

Prescription Information

Medication	Dosage & Strength	Directions	Qty	Refills
◯ Praluent	◯ 75mg/ml Prefilled Pen ◯ 75mg/ml Prefilled Syringe	◯ Inject 75mg SC every 2 weeks	2	
	◯ 150mg/ml Prefilled Pen ◯ 150mg/ml Prefilled Syringe	◯ Inject 150mg SC every 2 weeks ◯ Inject 300mg SC once a month	2	
◯ Repatha	◯ 140mg/ml SureClick Autoinjector ◯ 140mg/ml Prefilled Syringe	◯ Inject 140mg SC every 2 weeks	2	
		◯ Inject 420mg SC once a month	3	
	◯ 420mg/3.5ml Pushtronex system	◯ Inject single use Pushtronex system on body with prefilled cartridge once a month	1 Pack	
◯ Other				

Prescriber Signature

(I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ Signature_____ Date: _____

Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.