



# Hypercholesterolemia

Call: (877) 883-1392 Fax: (256)429-2221

**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: \_\_\_\_\_

Last 4 of SSN: \_\_\_\_\_

**Prescriber Information Please include front and back copies of insurance card.**

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:**  Yes  No **Statin:**  Yes  No **Niacin:**  Yes  No  
**If yes:**  Myopathy or Rhabdomyolysis  Hepatic Disease  Renal Dysfunction  
 Pregnancy or Lactation  Recent Stroke or TIA  Other: \_\_\_\_\_

Prior Failed Therapies	Drug Name & Length of Treatment
<input type="radio"/> Fibrates	
<input type="radio"/> Niacin	
<input type="radio"/> Omega-3	
<input type="radio"/> Statin	
<input type="radio"/> Zetia	
<input type="radio"/> Other	

**Laboratory Tests:**

<input type="radio"/> Lipid Panel	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
<input type="radio"/> Liver Function	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
<input type="radio"/> Renal Function	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____

**Injection Training:**  Patient Trained in MD Office  Pharmacy to Coordinate  
 Manufacturer Nurse Support  Physician's Office  
 Pharmacist to Provide Training  Patient's Home

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

**Prescription Information**

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

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**Substitution Permitted**  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**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.

**Confidentiality Notice:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.

