

HYPERCHOLESTEROLEMIA SPECIALTY CARE PROGRAM

Phone: **888-623-3133** • Fax: **844-673-2245**



1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____
Specialty: Cardiology Lipidology Other _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation and Laboratory Results)

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 _____

Laboratory Tests:

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

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

Prior Failed Therapies:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Fibrates	_____
<input type="checkbox"/> Niacin	_____
<input type="checkbox"/> Omega-3	_____
<input type="checkbox"/> Statin	_____
<input type="checkbox"/> Other	_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> PRALUENT®	<input type="checkbox"/> 75mg/ml Pre-filled Pen	<input type="checkbox"/> Inject 75mg SC every 2 weeks	2	
	<input type="checkbox"/> 150mg/ml Pre-filled Pen	<input type="checkbox"/> Inject 150mg SC every 2 weeks <input type="checkbox"/> Inject 300mg SC once a month	2	
<input type="checkbox"/> REPATHA®	<input type="checkbox"/> 140mg/ml SureClick® Auto Injector	<input type="checkbox"/> Inject 140mg SC every 2 weeks <input type="checkbox"/> Inject 420mg SC once a month <i>(Inject three 140mg/ml injections consecutively within 30 minutes)</i>	2 3	
	<input type="checkbox"/> 420mg/3.5ml Pushtronex® system	<input type="checkbox"/> Inject single use Pushtronex® system on body with prefilled cartridge	1 Pack	
<input type="checkbox"/> 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: _____ Date: _____ 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.

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