

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).

Hypercholesterolemia/Cardiology

Prescription/Pharmacy Intake Form

Pharmacy: _____
Pharmacy Fax: _____ Pharmacy Phone: _____
Date Needed: _____ Ship To: Prescriber's Office Patient's Home Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ Male Female
Address: _____
City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____
E-mail Address: _____ Case Manager: _____

Insurance provider (Please include copy of front and back of card): _____
ID #: _____ Policy/Group #: _____ Phone #: _____ Patient is eligible for Medicare
Name of Insured: _____ Employer: _____
Relationship to Patient: Self Other: _____ Prescription Card: Yes No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

Patient is new to therapy Patient is restarting therapy Patient is currently on therapy Start date: _____

ICD-10 Diagnosis Codes - Please select at least one primary and one secondary ICD-10 code

Primary diagnosis:

- Pure Hypercholesterolemia E78.00
- Familial Hypercholesterolemia E78.01
- Heterozygous (HeFH)
- Homozygous (HoFH)
- Mixed Hyperlipidemia E78.2
- Other Hyperlipidemia E78.4
- Hyperlipidemia, unspecified E78.5

Secondary diagnosis:

- G46. _____ Transient Cerebral Ischemia Attack
- I21. _____ I22. _____ I23. _____ Ischemic Heart Disease
- I25. _____ Chronic Ischemic Heart Disease
- I63. _____ I65. _____ I66. _____ I67. _____ Cerebrovascular Diseases
- I70. _____ Atherosclerosis
- I73. _____ Other Peripheral Vascular Diseases
- _____ Other

Current LDL-C: _____ mg/dL Date: _____ Allergies: _____

LIPID-LOWERING TREATMENT HISTORY – Previous and/or current

None Yes (please indicate below) Last date on lipid-lowering treatment: mm/dd/yyyy _____

	Dose	Start date	Stop date	Intolerant	Current		Dose	Start date	Stop date	Intolerant	Current
<input type="checkbox"/> atorvastatin	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> ezetimibe	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> pravastatin	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> rosuvastatin	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> simvastatin	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>						

Failure on or contraindications to any of the above therapies? _____

PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
LEQVIO (inclisiran injection)			
<input type="checkbox"/> 284 mg/1.5 mL Pre-Filled syringe	284mg subcutaneously initially, again at 3 months, and then every 6 months thereafter		
PRALUENT (alirocumab injection)			
<input type="checkbox"/> 75 mg/mL Pre-Filled Pen (2-Pack)	Inject 75 mg subcutaneously every 2 weeks		
<input type="checkbox"/> 150 mg/mL Pre-Filled Pen (2-Pack)	<input type="checkbox"/> Inject 150 mg subcutaneously every 2 weeks <input type="checkbox"/> Inject 300 mg (2x150 mg) subcutaneously once monthly		
REPATHA (evolocumab)			
<input type="checkbox"/> 140 mg/mL Pre-Filled syringe (2-Pack)	Inject 140 mg subcutaneously every 2 weeks		
<input type="checkbox"/> 140 mg/mL SureClick® autoinjector (2-Pack)	Inject 140 mg subcutaneously every 2 weeks		
<input type="checkbox"/> 420 mg/3.5 mL Pushtronex® system	Administer 420 mg subcutaneously via Pushtronex® on-body infuser system once monthly		

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____
Address: _____ City: _____ State: _____ Zip code: _____
Office contact: _____ Phone: _____ Fax: _____
Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.