



Fax: _____
Phone: _____

Hyperlipidemia Enrollment Form

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Home Phone _____ Alternate Phone _____
DOB _____ Last Four of SS# _____ Gender _____
Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis	Additional Information	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
<p>Please include diagnosis name and ICD-10 code</p> <p><input type="checkbox"/> E78.5 Hyperlipidemia</p> <p><input type="checkbox"/> E78.0 Hypercholesterolemia (Familial)</p> <p><input type="checkbox"/> Other Diagnosis: ICD-10 Code _____</p> <p>Description _____</p>	<p>Weight _____ kg/lbs Height _____ cm/in</p> <p>Allergies _____</p> <p>Lab Data _____</p> <p>Concomitant Medications _____</p> <p>Additional Comments _____</p>	

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Praluent® Injection	<input type="checkbox"/> 75 mg/mL Pen <input type="checkbox"/> 150 mg/mL Pen	<input type="checkbox"/> Inject 75 mg SQ every 2 weeks <input type="checkbox"/> Inject 150 mg SQ every 2 weeks <input type="checkbox"/> Inject 300 mg SQ every 4 weeks		
<input type="checkbox"/> Repatha® Injection	<input type="checkbox"/> 140 mg/mL Auto-injector <input type="checkbox"/> 140 mg/mL PFS <input type="checkbox"/> 420 mg/3.5 mL Cartridge	<input type="checkbox"/> Inject 140 mg SQ every 2 weeks <input type="checkbox"/> Inject 420 mg SQ once monthly		
<input type="checkbox"/> Other:				

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other _____ Date _____ Needs by Date _____

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____

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