HYPERCHOLESTEROLEMIA SPECIALTY PROGRAM

Phone: 844-223-7510
Fax: 844-673-6161

PATIENT INFORMATION:

Name: ________________________ Address: ________________________

City: ______________ State: ____ Zip: __________ Phone: ______________ Alt. Phone: ______________

Email: ______________________________ DOB: __________ Gender: ________ Height: ________

Weight: ________ Allergies: ____

PRESCRIBER INFORMATION:

Name: ________________________ Address: ________________________

City: ______________ State: ____ Zip: __________ Phone: ______________ Fax: ______________

NPI: ______________ DEA: ______________ Tax I.D.: ______________

Office Contact: ______________ Phone with Extension: ______________

STATEMENT OF MEDICAL NECESSITY:

Date of Diagnosis: ______________ Primary ICD-10: ______________ Secondary ICD-10: ______________

Contraindications: Myalgias Myopathy/Rhabdomyolysis Hepatic Disease Renal Dysfunction Pregnancy/Lactation TIA/Recent Stroke Other: ______________

Prior Treatments & Dates of Therapy (include Statins, Fibrates, Niacin, Omega-3, Zetia): ______________

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REQUIRED INFORMATION: Please fax copy of ***Prescription and Insurance Cards*** (front and back), as well as ***Clinical Chart Notes and Labs/Test Results (from within the last 90 days)***

PRESCRIPTION INFORMATION:

Patient Name: ________________________ Date of Birth: ______________

Medication	Strength	Directions	Quantity/Refills
Praluent®	75mg/ml Prefilled Pen	Inject 75mg subcutaneously every 2 weeks	**Qty:______Refills:____**
	150mg/ml Prefilled Pen	Inject 150mg subcutaneously every 2 weeks	**Qty:______Refills:____**
		Inject 300mg subcutaneously every 4 weeks	**Qty:______Refills:____**
Repatha®	140mg/ml SureClick® autoinjector	Inject 140mg subcutaneously every 2 weeks	**Qty:______Refills:____**
	420mg/3.5ml single-use Pushtronex™ system	Use the single-use Pushtronex™ system to inject 420mg over 9 minutes once monthly	**Qty:______Refills:____**

PHYSICIAN SIGNATURE REQUIRED:

SIGNATURE: ________________________ **DATE:** ______________