HYPERCHOLESTEROLEMIA SPECIALTY CARE PROGRAM

Phone: **844-378-3784** • Fax: **888-972-7058**

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: ____________

Supervising Physician: ____________ NPI: ________

Tax I.D.: ______________________________

Office Contact: ____________ Phone: ____________

Specialty: ❑ Cardiology ❑ Lipidology ❑ Other ________

v9.8_082918

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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: ____________

Prior Failed Therapies:	Indicate Drug Name and Length of Treatment:
❑ Fibrates	____________
❑ Niacin	____________
❑ Omega-3	____________
❑ Statin	____________
❑ Zetia	____________
❑ Other	____________

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

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

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
❑ PRALUENT®	❑ 75mg/ml Prefilled Pen ❑ 75mg/ml Prefilled Syringe	❑ Inject 75mg SC every 2 weeks	2	
	❑ 150mg/ml Prefilled Pen ❑ 150mg/ml Prefilled Syringe	❑ Inject 150mg SC every 2 weeks ❑ Inject 300mg SC once a month	2	
❑ REPATHA®	❑ 140mg/ml SureClick® Auto Injector ❑ 140mg/ml Prefilled Syringe	❑ Inject 140mg SC every 2 weeks	2	
		❑ Inject 420mg SC once a month *(Inject three 140mg/ml injections consecutively within 30 minutes)*	3	
	❑ 420mg/3.5ml Pushtronex® system	❑ Inject single use Pushtronex® system on body with prefilled cartridge once a month	1 Pack	
❑ 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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