

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: E78.0 (Pure hypercholesterolemia) E78.2 (Mixed hyperlipidemia) E78.4 (Other hyperlipidemia)

For ASCVD patients, MUST select appropriate code for Hypercholesterolemia AND ASVCD

Clinical ASCVD-specific code (s): _____

Lab Results: LDL-C _____ mg/ml **Result Date:** _____

Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____

Concomitant Medications: _____

Allergies: NKDA Other: _____

Prescription	Quantity	Refill
<input type="checkbox"/> Praluent® (alirocumab) <input type="checkbox"/> Inject 75 mg subcut every 2 weeks <input type="checkbox"/> Inject 150 mg subcut every 2 weeks	<input type="checkbox"/> 2 x 75 mg/mL <input type="checkbox"/> 2 x 150 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> Pen
<input type="checkbox"/> Repatha® (evolocumab) <input type="checkbox"/> Inject 140 mg subcut every 2 weeks <input type="checkbox"/> Inject 420 mg subcut every 4 weeks	<input type="checkbox"/> 2 x 140 mg/mL <input type="checkbox"/> 3 x 140 mg/mL	<input type="checkbox"/> PFS <input type="checkbox"/> SureClick® Autoinjector
Administer 420 mg subcut via on-body infusor over 9 minutes	1 x 420 mg/3.5 mL	Pushtronex™

Injection Training Provided by: Prescriber's Office Pharmacy Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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