

# Hypercholesterolemia



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: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	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)			
<b>Diagnosis:</b> <input type="checkbox"/> E78.00 (Pure hypercholesterolemia, unspecified) <input type="checkbox"/> E78.01 (Familial hypercholesterolemia - Homozygous <input type="checkbox"/> Heterozygous) <input type="checkbox"/> E78.2 (Mixed hyperlipidemia) <input type="checkbox"/> E78.4 (Other hyperlipidemia) <input type="checkbox"/> E78.5 (Hyperlipidemia, Unspecified)			
<i>For ASCVD patients, MUST select appropriate code for Hypercholesterolemia AND ASVCD</i>			
<b>Clinical ASCVD-specific code (s):</b> _____			
<b>Lab Results:</b> LDL-C _____ mg/dL <b>Result Date:</b> _____			
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: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Quantity	Refill
<input type="checkbox"/> <b>Praluent® (alirocumab)</b> <input type="checkbox"/> Inject 75 mg subcut every 2 weeks <input type="checkbox"/> Inject 150 mg subcut every 2 weeks <input type="checkbox"/> Inject 300 mg subcut every 4 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"/> <b>Repatha® (evolocumab)</b> <input type="checkbox"/> Inject 140 mg subcut every 2 weeks <input type="checkbox"/> Inject 420 mg subcut every 4 weeks  Administer 420 mg subcut via on-body infusor over 9 minutes	<input type="checkbox"/> 2 x 140 mg/mL <input type="checkbox"/> 3 x 140 mg/mL  1 x 420 mg/3.5 mL	<input type="checkbox"/> PFS <input type="checkbox"/> SureClick® Autoinjector  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: \_\_\_\_\_

*Stamp signature not allowed, physician signature required.*

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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