



EPATHA & PRALUENT REFERRAL FORM

Updated July 2019

Patient Name, Today's Date, NEW Patient, CURRENT Patient, DOB, Height, Weight, Male, Female, Preferred Language, Best Phone, Email, Street Address, Apt#, City, State, Zip, Ship to Patient at: Home, Physician Office, Work Address, Allergies, Current Medications including OTC's (please fax a complete list)

Please Fax Insurance Card(s) both sides

Insured's Name, Relation to Patient, Primary Insurance, ID#, Group #, Secondary Insurance, ID#, Group #

Ordering Prescriber

Office Contact, Street Address, Suite #, City, State, Zip, Tel, Fax, Email, License#, NPI#

ICD-10 Code, E78.0 HoFH Pure Hypercholesterolemia, E78.2 Mixed Hyperlipidemia, E78.5 Hyperlipidemia, unspecified

E78.01 HeFH Pure Hypercholesterolemia, E78.4 Other Hyperlipidemia, Other

Please add one secondary ICD-10-CM code:

Date of Diagnosis

Blood Pressure

Current smoker? Yes No

LDL-C Value mg/dL on date

Yes No Will patient continue to receive comprehensive counselling regarding appropriate diet?

Yes No Will patient continue to receive a low-fat diet and exercise regiment?

Yes No Will Repatha be used in combination w/ another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor?

Please attached a copy of patient's most recent lipid panel

PREVIOUS OR CURRENT LIPID LOWERING TREATMENTS

Table with columns: none, Strength/Freq, Dates of Therapy, Contraindications. Rows include Atorvastatin, Ezetimibe, Pravastatin, Rosuvastatin, Simvastatin, Pitavastatin, Ezetimibe/Simvastatin, Other.

PRESCRIPTION

PRALUENT (alirocumab), Pre-filled Pen 2-Pack, Pre-filled Syringe 2-Pack, 75 mg/mL, 150 mg/mL, SIG: Inject 75 mg OR 150 mg every 2 weeks, QTY: 1 month supply, 3 month supply, Other, Refills

REPATHA (evolocumab), 140 mg/ml single-use prefilled SureClick autoinjector, 140 mg/ml Pre-filled Syringe, 420 mg/3.5 mL single-use prefilled Pushtronex on-body infusor, SIG: Inject 140 mg subcutaneously every 2 weeks, QTY: 1 month supply, 3 month supply, Other, Refills

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS), Date

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.