REPATHA & 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 ☐ **E78.01** HeFH Pure Hypercholesterolemia
☐ **E78.2** Mixed Hyperlipidemia ☐ **E78.4** Other Hyperlipidemia
☐ **E78.5** Hyperlipidemia, unspecified ☐ 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

☐ none

	Strength/Freq	*Dates of Therapy*	*Contraindications*
☐ Atorvastatin (Lipitor®)	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Ezetimibe (Zetia®)	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Pravastatin (Pravachol®)	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Rosuvastatin (Crestor®)	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Simvastatin (Zocor®)	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Pitavastsatin (Livalo®)	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Ezetimibe/ Simvastatin (Vytorin®)	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Other_____	_____ mg/ _____	mm/yy _____ to _____	_____
☐ Other_____	_____ mg/ _____	mm/yy _____ to _____	_____

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
SIG: Inject ☐ 300 mg subcutaneously every 4 weeks
(to administer a 300 mg dose, give two150mg injections consecutively at two different injection sites)
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
SIG: ☐ Inject 420 mg subcutaneously once a month **(for E78.01 only)**
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. I certify this therapy to be medically necessary.
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.