HYPERCHOLESTEROLEMIA ENROLLMENT FORM

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Social Security No ______________________ Date of Birth ______________________

Sex □ M □ F Weight_______ Height_______ Allergies_________________

Home Phone ______________________ Work/Mobile ______________________

Home Address ______________________

City ______________ State ______________ Zip ______________

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______________________ Medical Insurance Phone ______________________

Subscriber Name ______________________

Rx Card (PBM) ______________________ Group No ______________________

Prescription Card Bin # ______________________ PCN # ______________________

TREATMENT ARRANGEMENTS

•Start Date:______________________ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Doctor's Office □ Other:_______________________________

CLINICAL INFORMATION

DIAGNOSIS/ICD-10:

Hypercholesterolemia

- □ E 78.0 Pure hypercholesterolemia
- □ E 78.2 Mixed hyperlipidemia
- □ E 78.4 Other hyperlipidemia

Clinical ASCVD

Ischemic heart Disease

- □ 122.__ Acute myocardial infarction
- □ 122.__ Subsequent myocardial infarction
- □ 120.9 Angina pectoris
- □ 125.__ Chronic ischemic heart disease

Other ASCVD-specific code(s) __________

Cerebrovascular and Peripheral Vascular Disease

- □ 163.__ Cerebral infarction
- □ 165.__ Occlusion and stenosis of cerebral arteries (Extracranial)
- □ 166.__ Occlusion and stenosis of cerebral arteries (Intracranial)
- □ 167.__ Other cerebrovascular disease
- □ 170.__ Atherosclerosis
- □ 173.9 Peripheral vascular disease
- □ _____ ______________________________________

PREVIOUS/CURRENT THERAPIES

- □ None
- □ atorvastatin ___mg/day
- □ ezetimibe ___mg/day
- □ ezetimibe /simvastatin ___mg/day
- □ rosuvastatin ___mg/day
- □ simvastatin ___mg/day

Date: ________________

Lab Results:

LDL-C __________ mg/ml Date: _________

PRESCRIPTION INFORMATION

Prescription	Strength	Directions	Quantity	Refills
□ **REPATHA™ (Evolocumab)**	□ 140 mg/mL PFS □ 140 mg/mL SureClick®	□ Inject 140mg subcutaneously every two (2) weeks □ Inject 420mg subcutaneously ONCE monthly	□ 28 days □ 84 days	_____
□ **PRALUENT™ (Alirocumab)**	□ 75 mg/mL Pen □ 75 mg/mL PFS □ 150 mg/mL Pen □ 150 mg/mL PFS	□ Inject 75 mg subcutaneously every two (2) weeks □ Inject 150 mg subcutaneously every two (2) weeks	□ 28 days	_____

Physician Signature: ______________________________ □ **DAW** (Dispense as Written) **Date:** ____________________

Physician Name: ________________ **Phone:** ____________ **Fax:** __________ **Office Contact:** ______________

Physician Address: ______________________________ **NPI:** ________________ **DEA:** ______________

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