REPATHA 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 ARRANGMENTS

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

Teaching by: □ Home Health □ Doctor's Office □ Other:_____

PATIENT MEDICAL INFORMATION:

Please provide one primary	**Please provide Secondary ICD -10-code*†:**		
ICD -10-CM code*†: □ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)‡ □ E78.2 Mixed Hyperlipidemia □ E78.4 Other Hyperlipidemia □ E78.5 Hyperlipidemia, Unspecified	□ 120.0 Unstable Angina □ 120.9 Angina Pectoris, Unspecified □ 122.___Acute Myocardial Infarction □ 122.___Subsequent Myocardial Infarction □ 125.___Chronic Ishemic Heart 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, Unspecified □ G45.9 Transient Cerebral Ischemic Attack, Unspecified □ G46.___Vascular Syndromes □ Other (specify ICD-10-CM): _____ _____

TREATMENT HISTORY (Dose in mg)

LDL-C on Treatment:_____ Date:_____

□ Atorvastatin (Lipitor®) □ 10mg □ 20mg □ 40mg □ 80mg

□ Rosuvastatin (Crestor®) □ 5mg □ 10mg □ 20mg □ 40mg

□ Simvastatin (Zocor®) □ 5mg □ 10mg □ 20mg □ 40mg

□ Ezetimibe (Zetia®) □ 10mg

□ Other statin/lipid-lowering medication (s):

_____

□ Achieved maxium tolerated statin dose?

□ Repatha™ was prescribed by, or in consultation with, a cardiologist, an endocrinologist, and/or a physician who focuses on the management of cardiovascular disease and/or lipid disorders.

Has the patient failed or they have contraindications to any of the above therapies?_____

_____

Other pertinent medical history or drug therapy:_____

_____

_____

_____

Family history of atherosclerotic cardiovascular disease (ASCVD):

_____

Allergies:_____

_____

PRESCRIPTION INFORMATION

Dose	Directions	Quantity	Refills
REPATHA™ (Evolocumab) 140 mg/ml Sure Click®	□ Inject 140mg subcutaneously every two (2) weeks □ Inject 420mg subcutaneously ONCE monthly	□ 28 days □ 84 days	_____

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

Physician Name: _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

Physician Address: _____ **NPI:** _____ **DEA:** _____

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