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:** _____

By signing this document you authorize Southside pharmacy to contact insurance companies for prior authorization purposes.

FAX TO 747-900-8489

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