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:________________________

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Family history of atherosclerotic cardiovascular disease (ASCVD):

____

Allergies:____

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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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