For assistance, contact your pharmacy representative: ________________ Phone:________________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

Hypercholesterolemia/Cardiology

Prescription/Pharmacy Intake Form

Pharmacy: ________________

Pharmacy Fax: ________________ Pharmacy Phone: ________________

Date Needed: ________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: ________________

PATIENT INFORMATION

Patient name: ________________ DOB: ________ ☐Male ☐Female

Address: ________________

City: ________________ State: ________ Zip code: ________

Phone # (Daytime): ________________ Phone # (Evening): ________________

E-mail Address: ________________ Case Manager: ________________

Insurance provider **(Please include copy of front and back of card)**: ________________

ID #: ________ Policy/Group #: ________ Phone #: ________ ☐Patient is eligible for Medicare

Name of Insured: ________________ Employer: ________________

Relationship to Patient: ☐Self ☐Other: ________ Prescription Card: ☐Yes ☐No Carrier: ________ Policy/Group #: ________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: ________

ICD-10 Diagnosis Codes - Please select at least one **primary** and one **secondary** ICD-10 code

Primary diagnosis:		**Secondary diagnosis:**	
Pure Hypercholesterolemia	☐E78.00	Transient Cerebral Ischemia Attack	☐G46.____
Familial Hypercholesterolemia	☐E78.01	Ischemic Heart Disease	☐I21.____ ☐I22.____ ☐I23.____
☐Heterozygous (HeFH)		Chronic Ischemic Heart Disease	☐I25.____
☐Homozygous (HoFH)		Cerebrovascular Diseases	☐I63.____ ☐I65.____ ☐I66.____ ☐I67.____
Mixed Hyperlipidemia	☐E78.2	Atherosclerosis	☐I70.____
Other Hyperlipidemia	☐E78.4	Other Peripheral Vascular Diseases	☐I73.____
Hyperlipidemia, unspecified	☐E78.5	Other ________	☐ ________

Current LDL-C: ________ mg/dL Date: ________ Allergies: ________________

LIPID-LOWERING TREATMENT HISTORY – Previous and/or current

☐None ☐Yes (please indicate below) Last date on lipid-lowering treatment: mm/dd/yyyy ________

	Dose	Start date	Stop date	Intolerant	Current		Dose	Start date	Stop date	Intolerant	Current
☐atorvastatin				☐	☐	☐ezetimibe				☐	☐
☐pravastatin				☐	☐	☐Other ________				☐	☐
☐rosuvastatin				☐	☐	☐Other ________				☐	☐
☐simvastatin				☐	☐						

☐Failure on or contraindications to any of the above therapies? ________________

PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
LEQVIO (inclisiran injection)			
☐284 mg/1.5 mL Pre-Filled syringe	284mg subcutaneously initially, again at 3 months, and then every 6 months thereafter		
PRALUENT (alirocumab injection)			
☐75 mg/mL Pre-Filled Pen (2-Pack)	Inject 75 mg subcutaneously every 2 weeks		
☐150 mg/mL Pre-Filled Pen (2-Pack)	☐Inject 150 mg subcutaneously every 2 weeks ☐Inject 300 mg (2x150 mg) subcutaneously once monthly		
REPATHA (evolocumab)			
☐140 mg/mL Pre-Filled syringe (2-Pack)	Inject 140 mg subcutaneously every 2 weeks		
☐140 mg/mL SureClick® autoinjector (2-Pack)	Inject 140 mg subcutaneously every 2 weeks		
☐420 mg/3.5 mL Pushtronex® system	Administer 420 mg subcutaneously via Pushtronex® on-body infuser system once monthly		

PRESCRIBER INFORMATION

Prescriber's name: ________________ Practice/facility: ________________

Address: ________________ City: ________ State: ____ Zip code: ________

Office contact: ________________ Phone: ________ Fax: ________

Email: ________________ Best time to call: ________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: ________ DEA #: ________ NPI #: ________ Medicaid UPIN #: ________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

________________ Dispense as written ________________ Substitution permitted ________________ Date

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.** The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.

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