Hypercholesterolemia

Patient Information	Prescriber + Shipping Information
Patient name: ________________________ DOB: ____________ Sex: ❑ Female ❑ Male SSN: ______________________________ Language: ____________ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in Address: ____ Apt/Suite: _____ City: ________________ State: _____ Zip: ______ Phone: ___________________ Alternate: ____________________ Caregiver name: ____________________ Relation: _____________ Local pharmacy: _____________________ Phone: _____________ Insurance plan: _________________ Plan ID: ________________ **Please fax a copy of front and back of the insurance card(s).**	Prescriber name: ______________________________________ NPI: ____ Address: ____ Apt/Suite: ______ City: ____________ State: _______ Zip: ______ Contact: ____ Phone: _____________________ Alternate: __________________ Fax: ____ Email: ____ If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ E78.00 (Pure hypercholesterolemia, unspecified) E78.01 (Familial hypercholesterolemia - Homozygous Heterozygous)
❑ E78.2 (Mixed hyperlipidemia) ❑ E78.4 (Other hyperlipidemia) ❑ E78.5 (Hyperlipidemia, Unspecified)

For ASCVD patients, MUST select appropriate code for Hypercholesterolemia AND ASVCD

Clinical ASCVD-specific code (s): _____________________ _____________________

Lab Results: LDL-C _____________________ mg/dL **Result Date:** _____________________

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
___________________________	____________________________________	__________________	__________________
___________________________	____________________________________	__________________	__________________
___________________________	____________________________________	__________________	__________________

Comorbidities: ____

Concomitant Medications: ____

Allergies: ❑ NKDA ❑ Other: ____

Prescription		Quantity		Refill
❑ **Praluent®** **(alirocumab)**	❑ Inject 75 mg subcut every 2 weeks ❑ Inject 150 mg subcut every 2 weeks Inject 300 mg subcut every 4 weeks	❑ 2 x 75 mg/mL ❑ 2 x 150 mg/mL	❑ PFS ❑ Pen	_____
❑ **Repatha®** **(evolocumab)**	❑ Inject 140 mg subcut every 2 weeks ❑ Inject 420 mg subcut every 4 weeks	❑ 2 x 140 mg/mL ❑ 3 x 140 mg/mL	❑ PFS ❑ SureClick® Autoinjector	_____
	Administer 420 mg subcut via on-body infusor over 9 minutes	1 x 420 mg/3.5 mL	Pushtronex™	_____

Injection Training Provided by: ❑ Prescriber's Office Pharmacy Other: ____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: ____________________________

Stamp signature not allowed, physician signature required.

Prescriber's Signature:____ Date: ____________

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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