ENVISIONSPECIALTY

Injectable Hypercholesterolemia Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ **New to Therapy**
☐ **Current Therapy**

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: M or F Caregiver: _____
Address: _____
City: _____State:_____ Zip:_____
Home Phone: _____ Work Phone:_____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Patient:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____

Prescriber Information

Practice/ Organization Name:_____
Prescriber Name: _____
Address: _____
City: _____State: _____ Zip: _____
Phone#:_____Fax#: _____
DEA#_____NPI# _____
License#:_____Medicaid UPIN#: _____
Physician Specialty: _____

Date Shipment Needed: _____
Ship to: ☐ Patient ☐ Prescriber ☐ Other: _____
Shipment Address: _____Attn:_____
City: _____State: _____Zip:_____
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

Clinical Information and Prescription

Diagnosis:
☐ E78.0 Pure hypercholesterolemia (including HeFH) ☐ E78.2 Mixed hyperlipidemia
☐ E78.4 Other hyperlipidemia ☐ E78.5 Unspecified hyperlipidemia
☐ ACVSD: _____ ☐Other: _____

Family History of Cardiovascular disease: _____

Previous Medications	Strength	Duration of Use	Reason for Discontinuation / Contraindication

LDL-C: _____mg/dL **Date**:_____ **Allergies:** _____

Injection training required? ☐ Not needed ☐Scheduled/Completed on _____ ☐ Pharmacy to arrange

☐**Praluent**® (alirocumab) – Inject SC once every 2 weeks x 1 month supply

☐75 mg/1mLPrefilled **Pen** ☐150 mg/1mL Prefilled **Pen**

☐**Repatha**® (evolocumab) – Inject 140 mg/mL SC every 2 weeks x 1 month supply

☐ SureClick® autoinjector ☐ Prefilled syringe

☐**Repatha**® (evolocumab) – Inject 420 mg/mL SC once monthly x 1 month supply

☐ SureClick® autoinjector ☐ Prefilled syringe

☐**Repatha**® (evolocumab) Pushtronex System

Inject 420 mg/3.5ml SC once monthly x 1 month supply

Refills Authorized: _____

X_____ ___/___/_____
Physician Signature (no stamps) **Date**