

<input type="checkbox"/> New to Therapy
<input type="checkbox"/> 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.

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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/1mL Prefilled 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**