

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation and Laboratory Results)

Date of Diagnosis: _____
Primary ICD-10: _____ Secondary ICD-10: _____
Other: _____

Contraindications:

Fibrates: Yes No Statin: Yes No Niacin: Yes No
If yes: Myopathy or Rhabdomyolysis Hepatic Disease Renal Dysfunction
 Pregnancy or Lactation Recent Stroke or TIA Other _____

Laboratory Tests:

Lipid Panel No Yes Date: _____
 Liver Function No Yes Date: _____
 Renal Function No Yes Date: _____

If Prior Authorization is Denied:

Automatically Draft Appeal for Review Send Formulary Preferred Alternatives

Prior Failed Therapies:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Fibrates	_____
<input type="checkbox"/> Niacin	_____
<input type="checkbox"/> Omega-3	_____
<input type="checkbox"/> Statin	_____
<input type="checkbox"/> Other	_____

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> PRALUENT™	<input type="checkbox"/> 75mg/ml Pre-filled Pen <input type="checkbox"/> 75mg/ml Pre-filled Syringe	<input type="checkbox"/> Inject 75mg SC every 2 weeks	2	
	<input type="checkbox"/> 150mg/ml Pre-filled Pen <input type="checkbox"/> 150mg/ml Pre-filled Syringe	<input type="checkbox"/> Inject 150mg SC every 2 weeks	2	
<input type="checkbox"/> REPATHA™	<input type="checkbox"/> 140mg/ml Pre-filled Syringe <input type="checkbox"/> 140mg/ml SureClick® Auto Injector	<input type="checkbox"/> Inject 140mg SC every 2 weeks <input type="checkbox"/> Inject 420mg SC once a month <i>(Inject three 140mg/ml injections consecutively within 30 minutes)</i>		
	<input type="checkbox"/> OTHER _____			

5 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

6 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____
Substitution Permitted
Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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