

PCSK9 Inhibitor (PRALUENT / REPATHA) - ENROLLMENT FORM

PATIENT INFORMATION

Name (First, Last): _____ ☐ Male ☐ Female
Address: _____ City: _____ State: ____ Zip Code: _____
Phone: (____) ____ - ____ Date of Birth: (mm/dd/yyyy) ____ / ____ / ____ Social Security# ____ - ____ - ____

PLEASE FAX COPY OF INSURANCE CARD, CHART NOTES AND LABS

| Medication | Dose/Strength | SIG | Quantity | Refills |
|--|---|--|--|---------|
| <input type="checkbox"/> PRALUENT | <input type="checkbox"/> 75 mg PEN INJ <input type="checkbox"/> 150 mg PEN INJ | <input type="checkbox"/> inject 1 dose subcutaneously every 2 weeks <input type="checkbox"/> inject 2 dose (300 mg total) every 4 weeks | <input type="checkbox"/> 2 pens | |
| <input type="checkbox"/> REPATHA (Sureclick Pen) | <input type="checkbox"/> 140 mg PEN INJ | <input type="checkbox"/> inject 1 dose subcutaneously every 2 weeks | <input type="checkbox"/> 2 pens | |
| <input type="checkbox"/> REPATHA (Pushtronix) | <input type="checkbox"/> 420 mg PUSHTRONEX | <input type="checkbox"/> inject 1 dose once monthly | <input type="checkbox"/> 3.5 ml (1 device) | |

Diagnosis (ICD10):

- ☐ Prevent and reduce the risk of future ASCVD events.
(No ICD10 listed)
- ☐ E78.5 Hyperlipidemia, Unspecified
- ☐ Z78.9 Statin Intolerance
- ☐ I25.10 Cardiovascular disease, unspecified
- ☐ I20.9 Angina Pectoris, Unspecified
- ☐ I73.9 Peripheral vascular disease, unspecified
- ☐ Z82.49 Family history of ischemic heart disease and other diseases of the circulatory system
- ☐ Z95.5 Presence of coronary angioplasty implant and graft stent
- ☐ I25.2 Old myocardial infarction
- ☐ E78.01 Familial hypercholesterolemia
- ☐ M62.82 Rhabdomyolysis
- ☐ _____
- ☐ _____
- ☐ _____

Previously tried/failed therapies & dates:

- ☐ Crestor Date: ____ / ____ / ____
- ☐ Lipitor Date: ____ / ____ / ____
- ☐ Pravastatin Date: ____ / ____ / ____
- ☐ Simvastatin Date: ____ / ____ / ____
- ☐ Zetia Date: ____ / ____ / ____
- ☐ Niacin Date: ____ / ____ / ____
- ☐ Cholestyramine Date: ____ / ____ / ____
- ☐ Colestipol Date: ____ / ____ / ____
- ☐ Dicyclomine Date: ____ / ____ / ____
- ☐ Hyoscyamine Date: ____ / ____ / ____
- ☐ Tricyclic Antidepressants Date: ____ / ____ / ____
- ☐ SSRI Date: ____ / ____ / ____
- ☐ Clonidine Date: ____ / ____ / ____
- ☐ Other Therapies _____
- _____
- _____
- _____

Total # of Dangerous Drugs Prescribed _____

PRESCRIBER'S INFORMATION

Prescriber Name (First, Last): _____ NPI #: _____
Address: _____ DEA #: _____
City: _____ State: ____ Zip Code: _____
Phone: (____) ____ - ____ Fax: (____) ____ - ____ Contact Name: _____

Physician Signature: _____ Date: ____ / ____ / ____

I authorize 986 Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.