986 PHARMACY SPECIALTY

1719 E. Walnut St Pasadena, CA 91106
Phone 626-798-6789 Fax 626-798-8376

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
☐ **PRALUENT**	☐ 75 mg PEN INJ ☐ 150 mg PEN INJ	☐ inject 1 dose subcutaneously every 2 weeks ☐ inject 2 dose (300 mg total) every 4 weeks	☐ 2 pens	
☐ **REPATHA (Sureclick Pen)**	☐ 140 mg PEN INJ	☐ inject 1 dose subcutaneously every 2 weeks	☐ 2 pens	
☐ **REPATHA (Pushtronix)**	☐ 420 mg PUSHTRONEX	☐ inject 1 dose once monthly	☐ 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