Hypercholesterolemia

phone: 1.877.829.3137
fax: 1.417.869.0277

Patient Information

patient: _____ ☐ male ☐ female DOB: _____ SS#: _____
(last name, first name)

address: _____
(street, city, state, zip)

primary phone number: _____ ☐ cell alternate phone number: _____ ☐ cell

caregiver: _____ allergies: _____ ☐ NKDA

comorbidities: _____ ***height:*** _____ ***weight:*** _____ ☐ lbs ☐ kg date: _____

Clinical Information

Diagnosis/ICD-10:

Hypercholesterolemia *(MUST select at least one)*

☐ E78.0 Pure hypercholesterolemia
☐ E78.2 Mixed hyperlipidemia
☐ E78.4 Other hyperlipidemia

For ASCVD patients, MUST select appropriate code for Hypercholesterolemia AND ASVCD

Clinical ASCVD
ASCVD-specific code(s) _____

Previous/Current Therapies:

☐ none		
☐ atorvastatin	_____ mg/day	date(s): _____
☐ ezetimibe	_____ mg/day	date(s): _____
☐ ezetimibe/simvastatin	_____ mg/day	date(s): _____
☐ pravastatin	_____ mg/day	date(s): _____
☐ rosuvastatin	_____ mg/day	date(s): _____
☐ simvastatin	_____ mg/day	date(s): _____

Lab Results:
LDL-C _____ mg/ml
Result Date _____

Prescription	strength	directions	quantity	refill
☐ Praluent®	☐ 75 mg/mL Pen ☐ 75 mg/mL PFS	Inject 75 mg sub-Q every 2 weeks	1 carton = 2 x 75 mg/mL	
	☐ 150 mg/mL Pen ☐ 150 mg/mL PFS	Inject 150 mg sub-Q every 2 weeks	1 carton = 2 x 150 mg/mL	
☐ Repatha™	☐ 140 mg/mL PFS ☐ 140 mg/mL SureClick®	☐ Inject 140 mg sub-Q every 2 weeks ☐ Inject 420 mg sub-Q every 4 weeks	☐ 1 pack = 1 x 140 mg/mL PFS ☐ 1 pack = 2 x 140 mg/mL SureClick® ☐ 2 pack = 4 x 140 mg/mL SureClick® ☐ 3 pack = 6 x 140 mg/mL SureClick®	

Injection Training

☐ Patient received injection training ☐ Prescriber's office to provide injection training ☐ Thrifty White Pharmacy to coordinate injection training

Prescriber + Shipping information

prescriber (print): _____ office contact: _____

preferred method of contact: ☐ phone ☐ fax ☐ email preferred contact persons email: _____

ship to: ☐ patient ☐ office ☐ alternate _____
(shipping address: street, city, state, zip)

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____

prescriber's signature: _____ date: _____

I authorize Dan's Discount Drug Mart and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Insurance Information: please fax copy of insurance card (front + back)