

Hypercholesterolemia



phone: 1.877.829.3137
fax: 1.417.869.0277

Patient Information

patient: _____ male
last name, first name female DOB: _____ SS#: _____
 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 <small>For ASCVD patients, MUST select appropriate code for Hypercholesterolemia AND ASVCD</small> 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 _____
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Prescription	strength	directions	quantity	refill
Praluent®	75 mg/mL Pen	Inject 75 mg sub-Q every 2 weeks	1 carton = 2 x 75 mg/mL	
	75 mg/mL PFS			
	150 mg/mL Pen	Inject 150 mg sub-Q every 2 weeks	1 carton = 2 x 150 mg/mL	
	150 mg/mL PFS			
Repatha™	140 mg/mL PFS	Inject 140 mg sub-Q every 2 weeks	1 pack = 1 x 140 mg/mL PFS	
	140 mg/mL SureClick®	Inject 420 mg sub-Q every 4 weeks	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)

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