ameripharma SPECIALTY CARE

Hypercholesterolemia

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ E78.0 (Pure hypercholesterolemia) ☐ (Mixed hyperlipidemia) ☐ (Other hyperlipidemia)

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

Clinical ASCVD-specific code(s): _____ _____

Lab Results: LDL-C _____ mg/mL **Result Date:** _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Start Date	End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription	Directions, Quantity, Form			Refill
☐ **Praluent®** (alirocumab)	☐ Inject 75 mg subq every 2 weeks ☐ Inject 150 mg subq every 2 weeks	☐ 2 x 75 mg/mL ☐ 2 x 150 mg/mL	☐ PFS ☐ Pen	
☐ **Repatha®** (evolocumab)	☐ Inject 140 mg subq every 2 weeks ☐ Inject 420 mg subq every 4 weeks	☐ 2 x 140 mg/mL ☐ 3 x 140 mg/mL	☐ PFS ☐ SureClick® Autoinjector	
	☐ Administer 420 mg subq via on-body infuser over 9 minutes	☐ 1 x 420 mg/3.5 mL	☐ Pushtronex™	

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: _____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Reset Form