Hypercholesterolemia

alps Specialty Pharmacy

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PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, ZIP: _____

Home Phone: _____ Alternate Phone: _____

Caregiver: _____ Email : _____

DOB: _____ Social Security#: _____

Gender: ☐ Male ☐ Female Comorbidities: _____

Height: _____ Weight: _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

NPI: _____ Tax-ID# : _____

DEA: _____

Office Contact: _____ Phone: _____

Contact Email: _____

INSURANCE INFORMATION

Please fax a copy of patients' insurance cards (prescription and medical, FRONT and BACK) including any secondary insurance.

CLINICAL INFORMATION [Please attach separate sheet if needed.]

Diagnosis

Diagnosis and IDC-10 code: _____

Date of Diagnosis: _____

Primary Code *(MUST select at least one)*

- ☐ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)
- ☐ E78.2 Mixed Hyperlipidemia
- ☐ E78.4 Other Hyperlipidemia
- ☐ E78.5 Hyperlipidemia, Unspecified

Secondary Code *(check all that apply)*

- ☐ I20.0 Unstable Angina
- ☐ I20.9 Angina Pectoris, Unspecified
- ☐ I21.___ Acute Myocardial Infarction
- ☐ I22.___ Subsequent Myocardial Infarction
- ☐ I25.___ Chronic Ischemic Heart Disease
- ☐ I63.___ Cerebral Infarction
- ☐ I65.___ Occlusion and Stenosis of Cerebral Arteries, Extracranial
- ☐ I66.___ Occlusion and stenosis of Cerebral Arteries, Intracranial
- ☐ I67.___ Other Cerebrovascular Diseases
- ☐ I70.___ Atherosclerosis
- ☐ I73.9 Peripheral Vascular Diseasem Unspecified
- ☐ G45.9 Transcient Cerebral Ischemic Attack, Unspecified
- ☐ G46.___ Vascular Syndromes

Other ASCVD-specific code(s): fasv

Prior History / Current Therapies

Please include a detailed medication history of statin therapy - doses, durations, and any ADE/ADR's experienced.

- ☐ None
- ☐ Atorvastatin Dose: _____ mg/day Date: _____
- ☐ Pravastatin Dose: _____ mg/day Date: _____
- ☐ Rosuvastatin Dose: _____ mg/day Date: _____
- ☐ Simvastatin Dose: _____ mg/day Date: _____
- ☐ Ezetimibe Dose: _____ mg/day Date: _____
- ☐ Other: _____ Dose: _____ mg/day Date: _____
- ☐ Other: _____ Dose: _____ mg/day Date: _____
- ☐ Other: _____ Dose: _____ mg/day Date: _____

Lab Results:

LDL-C _____ mg/ml

Result Date _____

Concurrent Medications: _____

Additional Information: _____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ 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 SureClick®	☐ Inject 140 mg sub-Q every 2 weeks	☐ 2 pack = 2 x 140 mg/mL SureClick®	
	☐ 420mg/3.5mL Pushtronex	☐ Inject 420 mg sub-Q every 4 weeks	☐ 1 pack = 1 x 420mg/mL Pushtronex	

INJECTION TRAINING

☐ To Be Administered by Pharmacist ☐ Pharmacist to Provide Training ☐ Patient Trained in MD Office ☐ Manufacturer Nurse Support

PRESCRIPTION DELIVERY

☐ Patient's Home ☐ Physician's Office ☐ Patient Will Pick Up in Pharmacy Date Issued: _____ Needs by Date: _____

PRESCRIBER AUTHORIZATION

I authorize Alps Pharmacy, including it's representatives and subcontractors, to act as my agent to initiate and execute the insurance prior authorization, patient assistance, and nursing programs. If Alps Pharmacy is unable to fulfill this prescription, I authorize Alps Pharmacy to forward this information and data related to the coverage of this prescription to another pharmacy.

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____

PRODUCT SUBSTITUTION PERMITTED ***Dispense As Written***

CONFIDENTIALITY NOTICE

Disclaimer: Alps can accept only original prescription drug orders from patients, and faxed prescriptions can be accepted only from the prescribing practitioners.