PCSK9 Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins.

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

Diagnosis

☐ E78.01 Familial Hypercholesterolemia
Type: ☐ HeFH (Heterozygous) ☐ HoFH (Homozygous)
☐ E78.0 Pure Hypercholesterolemia
☐ E78.2 Mixed Hyperlipidemia
☐ E78.4 Other Hyperlipidemia
☐ E78.5 Unspecified Hyperlipidemia
☐ Other _____
ICD 10 code: _____

Additional Clinical Information

Please attach clinical office notes and most recent labwork to expedite the prior authorization.

Secondary Diagnosis Codes: ☐ Acute Coronary Syndrome (I24.9) ☐ History of myocardial infarction (I25.2) ☐ Cerebral Infarction (I63.9) ☐ Angina (Stable or Unstable) (I20.9) ☐ Coronary or other arterial revascularization (I25.810)

Has patient had prior treatment for this diagnosis? ☐ Yes ☐ No

Date(s) of previous therapy and medication: _____

Reason(s) for discontinuation: _____

Has the patient tried any therapies/modifications? (Documentation of failure is requested.) ☐ Diet ☐ Exercise ☐ Ezetimibe

Desired start date of therapy: _____/_____/_____

Prescription

Medication	Strength	Directions	Quantity	Refills
☐ Praluent®	☐ 75mg/ml Pen ☐ 75mg/ml syringe	☐ Inject 75mg subcutaneously every 14 days	☐ #2 doses	
	☐ 150mg/ml Pen ☐ 150mg/ml syringe	☐ Inject 150mg subcutaneously every 14 days ☐ Inject 300mg subcutaneously every 28 days		
☐ Repatha®	☐ 140mg/ml autoinjector ☐ 140mg/ml syringe	☐ Inject contents of one pen/syringe (140mg) subcutaneously every 14 days	☐ #2 doses	
	☐ 420mg/3.5ml Pushtronex® System	☐ Inject 420 mg subcutaneously once monthly *(over 9 minutes by using the on-body infusor)*	#1 dose	

Supplies

☐ Sharps Container ☐ Alcohol Swabs

Injection Training

☐ Will be conducted at prescriber's office
☐ Value Specialty Pharmacy to provide training

Is patient new to this therapy? ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right. ☐