PCSK9 Enrollment Form

Patient Data

Patient Name: ______________________ Birthdate: __________
Sex: ❑ Male ❑ Female Height: _____ Weight: _______ lbs ____ kg _____
SSN #: XXX-XX-______________________
Known Allergies: ______________________
Address: ______________________
City: ____________ State: ________ Zip: ________
Home Phone: ____________ Cell Phone: ____________
Primary Language: ______________________
Alternate Caregiver Name: ______________________
Phone of Caregiver: ______________________

Ins.

Primary Insurance: ______________________
Secondary Insurance: ______________________
Policy: ______________________ Group#: __________
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: ______________________
DEA#: ______________ NPI: ______________
Practice Name: ______________________
Contact: ______________ Preferred Method: ❑ Phone ❑ Fax ❑ Email
Address: ______________________
Phone: ______________ Fax: ______________
City: ____________ State: ________ Zip: ________
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.

fax referral to: **901-388-0407** | phone: **877-388-0507** | **www.restorerx.com**