

PATIENT INFORMATION

Name: _____ Address: _____ Phone: _____
 SSN: _____ DOB: _____ Sex: _____
 Weight: _____ Height: _____ Allergies: _____ Ship to: Patient Clinic

INSURANCE

Prescription Card: _____ Name of Insurer: _____ ID# _____ BIN: _____ PCN: _____
 Group: _____ (Please attach copies of insurance cards.)

DIAGNOSIS

E78.0 Pure Hypercholesterolemia E78.2 Mixed Hyperlipidemia E78.4 Other Hyperlipidemia E78.5 Hyperlipidemia, Unspecified
 Clinical ASCVD-Specific Codes: _____
 Previous Therapy: _____ Start Date: _____ End Date: _____ Reason for DC: _____
 Active Medication List: _____
 Lab Results: _____
 LDL-C: _____ mg/ml Result Date: _____

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refill
<input type="checkbox"/> Praluent (Alirocumab)	<input type="checkbox"/> 75 mg/ml PFS <input type="checkbox"/> 75 mg/ml Pen <input type="checkbox"/> 150 mg/ml PFS <input type="checkbox"/> 150 mg/ml Pen	<input type="checkbox"/> Inject 75 mg SC every 2 weeks <input type="checkbox"/> Inject 150 mg every 2 weeks	<input type="checkbox"/> 2 X 75 mg/ml <input type="checkbox"/> 2 X 150 mg/ml	
<input type="checkbox"/> Repatha (Evolocumab)	<input type="checkbox"/> 140 mg/ml PFS <input type="checkbox"/> 140 mg/ml sureclick <input type="checkbox"/> 420 mg/3.5 ml pushtronex	<input type="checkbox"/> Inject 140 mg SC every 2 weeks <input type="checkbox"/> Inject 420 mg SC monthly	<input type="checkbox"/> 2 X 140 mg/ml <input type="checkbox"/> 3 X 140 mg/ml <input type="checkbox"/> 1 X 420 mg/ 3.5ml	
<input type="checkbox"/> Other				

PRESCRIBER INFORMATION

Physician Name: _____ Address: _____
 State License#: _____ NPI: _____ DEA: _____
 Phone #: _____ Fax #: _____ Office Contact Name /Number: _____
 Prescriber's Signature: _____ Date: _____

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