Hypercholesterolemia

toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

patient: ______________________ (last name, first name) male / female DOB: ________ SS#: ____________

address: ______________________ (street, city, state, zip)

primary phone number: ____________ cell alternate phone number: ____________ cell

caregiver: ____________ allergies: ____________ NKDA

comorbidities: ____________ ***height:*** ________ ***weight:*** ________ lbs / kg date: ____________

Clinical Information

Diagnosis/ICD-10:

Hypercholesterolemia *(MUST select at least one)*

E78.0 Pure hypercholesterolemia
E78.2 Mixed hyperlipidemia
E78.4 Other hyperlipidemia

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

Clinical ASCVD
ASCVD-specific code(s) ____________

Previous/Current Therapies:

none
atorvastatin _____ mg/day date(s): ____________
ezetimibe _____ mg/day date(s): ____________
ezetimibe/simvastatin _____ mg/day date(s): ____________
pravastatin _____ mg/day date(s): ____________
rosuvastatin _____ mg/day date(s): ____________
simvastatin _____ mg/day date(s): ____________

Lab Results:

LDL-C ____________ mg/ml
Result Date ____________

Prescription	strength	directions	quantity	refill
Praluent®	75 mg/mL Pen	Inject 75 mg sub-Q every 2 weeks	1 carton = 2 x 75 mg/mL	
	150 mg/mL Pen	Inject 150 mg sub-Q every 2 weeks	1 carton = 2 x 150 mg/mL	
Repatha™	140 mg/mL PFS 140 mg/mL SureClick®	Inject 140 mg sub-Q every 2 weeks Inject 420 mg sub-Q every 4 weeks	1 pack = 1 x 140 mg/mL PFS 1 pack = 2 x 140 mg/mL SureClick® 2 pack = 4 x 140 mg/mL SureClick® 3 pack = 6 x 140 mg/mL SureClick®	

Injection Training

Patient received injection training   Prescriber's office to provide injection training   Thrifty White Pharmacy to coordinate injection training

Prescriber + Shipping information

prescriber (print): ____________ office contact: ____________

preferred method of contact: phone fax email preferred contact persons email: ____________

ship to: patient office alternate ____________ (shipping address: street, city, state, zip)

office address: ____________ (street, suite, city, state, zip)

phone: ____________ fax: ____________ NPI: ____________

prescriber's signature: ____________ date: ____________

I authorize Thrifty White Specialty Pharmacy 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 Thrifty White Specialty Pharmacy.

Insurance Information: please fax copy of insurance card (front + back)

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