

**1 PATIENT INFORMATION:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**2 PRESCRIBER INFORMATION:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax I.D.: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation and Laboratory Results)**

Date of Diagnosis: \_\_\_\_\_  
 Primary ICD-10: \_\_\_\_\_ Secondary ICD-10: \_\_\_\_\_  
 Other: \_\_\_\_\_

Contraindications:  
 Fibrates:  Yes  No Statin:  Yes  No Niacin:  Yes  No  
 If yes:  Myopathy or Rhabdomyolysis  Hepatic Disease  Renal Dysfunction  
 Pregnancy or Lactation  Recent Stroke or TIA  Other \_\_\_\_\_

**Laboratory Tests:**  
 Lipid Panel  No  Yes Date: \_\_\_\_\_  
 Liver Function  No  Yes Date: \_\_\_\_\_  
 Renal Function  No  Yes Date: \_\_\_\_\_

Prior Failed Therapies:	Indicate Drug Name and Length of Treatment:
<input type="checkbox"/> Fibrates	_____
<input type="checkbox"/> Niacin	_____
<input type="checkbox"/> Omega-3	_____
<input type="checkbox"/> Statin	_____
<input type="checkbox"/> Other	_____

**If Prior Authorization is Denied:**  
 Automatically Draft Appeal for Review  Send Formulary Preferred Alternatives

**4 PRESCRIPTION INFORMATION:**

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> PRALUENT™	<input type="checkbox"/> 75mg/ml Pre-filled Pen <input type="checkbox"/> 75mg/ml Pre-filled Syringe	<input type="checkbox"/> Inject 75mg SC every 2 weeks	2	
	<input type="checkbox"/> 150mg/ml Pre-filled Pen <input type="checkbox"/> 150mg/ml Pre-filled Syringe	<input type="checkbox"/> Inject 150mg SC every 2 weeks	2	
<input type="checkbox"/> REPATHA™	<input type="checkbox"/> 140mg/ml Pre-filled Syringe	<input type="checkbox"/> Inject 140mg SC every 2 weeks		
	<input type="checkbox"/> 140mg/ml SureClick® Auto Injector	<input type="checkbox"/> Inject 420mg SC once a month <i>(Inject three 140mg/ml injections consecutively within 30 minutes)</i>		
<input type="checkbox"/> OTHER _____				

**5 INJECTION TRAINING:**  Pharmacist to Provide Training  Patient Trained in MD Office  Manufacturer Nurse Support

**6 PRODUCT DELIVERY:**  Patient's Home  Physician's Office  Pharmacy to Coordinate

**7 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**8 PRESCRIBER SIGNATURE:** I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**Substitution Permitted** **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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