



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. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Diagnosis

E78.01 Familial Hypercholesterolemia Type: HeFH (Heterozygous) HoFH (Homozygous) E78.4 Other Hyperlipidemia
 E78.0 Pure Hypercholesterolemia E78.5 Unspecified Hyperlipidemia
 E78.2 Mixed 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
<input type="checkbox"/> Praluent®	<input type="checkbox"/> 75mg/ml Pen	Inject 75mg subcutaneously every 14 days	#2 doses	
	<input type="checkbox"/> 75mg/ml syringe			
<input type="checkbox"/> Repatha®	<input type="checkbox"/> 150mg/ml Pen	<input type="checkbox"/> Inject 150mg subcutaneously every 14 days <input type="checkbox"/> Inject 300mg subcutaneously every 28 days	#2 doses	
	<input type="checkbox"/> 150mg/ml syringe			
	<input type="checkbox"/> 140mg/ml autoinjector <input type="checkbox"/> 140mg/ml syringe	Inject contents of one pen/syringe (140mg) subcutaneously every 14 days	#2 doses	
	<input type="checkbox"/> 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: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy 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 Value Specialty 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.

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