ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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SPASSIST®
HYPERCHOLESTEROLEMIA ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 10.31.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com

Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: Diagnosis/ICD-10-CM Codes: ☐E78.00 Pure Hypercholesterolemia, unspecified ☐E78.01 Familial Hypercholesterolemia ☐E78.2 Mixed Hyperlipidemia ☐E78.4 Other Hyperlipidemia ☐E78.5 Hyperlipidemia, unspecified ☐Other_____

Secondary ICD-10 (select all that apply): ☐I20.0 Unstable Angina ☐I20.9 Angina Pectoris ☐I21.__ Acute Myocardial Infarction ☐I22.__ Subsequent Myocardial Infarction ☐I25.__ Chronic Ischemic Heart Disease ☐I63.__ Cerebral Infarction ☐Other_____

Clinical Information: Treatment History (Lipid-lowering Agents)

Medication	Dose	Start date	Stop date	Intolerant?	Current?

Lab Results: (please attach a copy of patients most recent lipid panel)

LDL-C on Treatment: _____ Date: _____
Has the patient achieved their maximum tolerated statin dose? _____
Has the patient failed on or do they have contraindications to any of the above therapies? _____
Other pertinent medical history or drug therapy: _____
Family history of established cardiovascular disease (CVD): _____

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐**Praluent®** (alirocumab)	☐75 mg/mL Prefilled Pen (2-Pack) ☐150 mg/mL Prefilled Pen (2-Pack)	☐Inject 75mg (1 mL) SQ every 2 weeks ☐Inject 150mg (1 mL) SQ every 2 weeks ☐Inject 300mg (2 mL) SQ every 4 weeks ☐Other _____	☐4 week supply ☐Other:_____	
☐**Repatha®** (evolocumab)	☐140 mg/mL SureClick® (2-Pack) ☐140 mg/mL Prefilled Syringe (1-Pack) ☐420 mg/3.5mL PUSHTRONEX® (infuser with prefilled cartridge)	☐Inject 140mg (1 mL) SQ every 2 weeks ☐Inject 420mg (3 mL) SQ every 4 weeks ☐Inject 420mg (via PUSHTRONEX®) SQ every 4 weeks ☐Other _____	☐4 week supply ☐Other:_____	
☐**Other**			**SQ = subcutaneously**	

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ ☐DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)_____ Date:_____ □ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program