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## HYPERCHOLESTEROLEMIA ENROLLMENT FORM

Today's Date: \_\_\_\_\_  
 Needed By: \_\_\_\_\_

Last update 10.31.2018



www.commcarepharmacy.com  
 Plantation, FL  
 Phone: 888.203.7973  
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 NCPDP: 1079638  
 NPI: 1598762015

<b>Patient Demographics:</b> (Please provide the following or attach demographics sheet)		<b>Provider Office:</b> (Please provide as much information as possible)	
Patient Name: _____		Prescriber's Name: _____ Group/Hospital: _____	
Address: _____		Specialty: _____ License#: _____ Tax ID#: _____	
City, State, Zip: _____		Address: _____	
Preferred Phone: _____ Alt. Phone: _____		NPI: _____ DEA: _____	
Last four digits of SS#: _____ Date of Birth: _____		City, State, Zip: _____	
Gender: __ Allergies: _____ Height: _____ Weight: _____		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
<input type="checkbox"/> <b>Praluent®</b> (alirocumab)	<input type="checkbox"/> 75 mg/mL Prefilled Pen (2-Pack) <input type="checkbox"/> 150 mg/mL Prefilled Pen (2-Pack)	<input type="checkbox"/> Inject 75mg (1 mL) SQ every 2 weeks <input type="checkbox"/> Inject 150mg (1 mL) SQ every 2 weeks <input type="checkbox"/> Inject 300mg (2 mL) SQ every 4 weeks <input type="checkbox"/> Other _____	<input type="checkbox"/> 4 week supply  <input type="checkbox"/> Other: _____	
<input type="checkbox"/> <b>Repatha®</b> (evolocumab)	<input type="checkbox"/> 140 mg/mL SureClick® (2-Pack) <input type="checkbox"/> 140 mg/mL Prefilled Syringe (1-Pack) <input type="checkbox"/> 420 mg/3.5mL PUSHTRONEX® (infuser with prefilled cartridge)	<input type="checkbox"/> Inject 140mg (1 mL) SQ every 2 weeks <input type="checkbox"/> Inject 420mg (3 mL) SQ every 4 weeks <input type="checkbox"/> Inject 420mg (via PUSHTRONEX®) SQ every 4 weeks <input type="checkbox"/> Other _____	<input type="checkbox"/> 4 week supply  <input type="checkbox"/> Other: _____	
<input type="checkbox"/> <b>Other</b>				

**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

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