For assistance, contact your pharmacy representative: _____ Phone: _____ **(For providers only)**

**PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.**

**Note:** This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens + PRIME

# Hypercholesterolemia/Cardiology

Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone: _____

**Date Needed:** _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

## PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

## CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: _____

**ICD-10 Diagnosis Codes** - Please select at least one **primary** and one **secondary** ICD-10 code

| **Primary diagnosis:** | | **Secondary diagnosis:** | |
|---|---|---|---|
| Pure Hypercholesterolemia | ☐E78.00 | Transient Cerebral Ischemia Attack | ☐G46._____ |
| Familial Hypercholesterolemia | ☐E78.01 | Ischemic Heart Disease | ☐I21._____ ☐I22._____ ☐I23._____ |
| ☐Heterozygous (HeFH) | | Chronic Ischemic Heart Disease | ☐I25._____ |
| ☐Homozygous (HoFH) | | Cerebrovascular Diseases | ☐I63._____ ☐I65._____ ☐I66._____ ☐I67._____ |
| Mixed Hyperlipidemia | ☐E78.2 | Atherosclerosis | ☐I70._____ |
| Other Hyperlipidemia | ☐E78.4 | Other Peripheral Vascular Diseases | ☐I73._____ |
| Hyperlipidemia, unspecified | ☐E78.5 | Other _____ | ☐ _____ |

Current LDL-C: _____ mg/dL Date: _____ Allergies: _____

## LIPID-LOWERING TREATMENT HISTORY – Previous and/or current

☐None ☐Yes (please indicate below) Last date on lipid-lowering treatment: mm/dd/yyyy _____

| | Dose | Start date | Stop date | Intolerant | Current | | Dose | Start date | Stop date | Intolerant | Current |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐atorvastatin | | | | ☐ | ☐ | ☐ezetimibe | | | | ☐ | ☐ |
| ☐pravastatin | | | | ☐ | ☐ | ☐Other _____ | | | | ☐ | ☐ |
| ☐rosuvastatin | | | | ☐ | ☐ | ☐Other _____ | | | | ☐ | ☐ |
| ☐simvastatin | | | | ☐ | ☐ | | | | | | |

☐Failure on or contraindications to any of the above therapies? _____

## PRESCRIPTION INFORMATION

| Medication | Directions | Quantity | Refills |
|---|---|---|---|
| **PRALUENT (alirocumab injection)** | | | |
| ☐75 mg/mL Pre-Filled Pen (2-Pack) | Inject 75 mg subcutaneously every 2 weeks | | |
| ☐150 mg/mL Pre-Filled Pen (2-Pack) | ☐Inject 150 mg subcutaneously every 2 weeks<br>☐Inject 300 mg (2x150 mg) subcutaneously once monthly | | |
| **REPATHA (evolocumab)** | | | |
| ☐140 mg/mL Pre-Filled syringe (2-Pack) | Inject 140 mg subcutaneously every 2 weeks | | |
| ☐140 mg/mL SureClick® autoinjector (2-Pack) | Inject 140 mg subcutaneously every 2 weeks | | |
| ☐420 mg/3.5 mL Pushtronex® system | Administer 420 mg subcutaneously via Pushtronex® on-body infuser system once monthly | | |

## PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

**The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.**