

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: Female Male SSN: _____ Language: _____ Wt: _____ kg lbs Ht: _____ cm in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: E78.0 (Pure hypercholesterolemia) E78.2 (Mixed hyperlipidemia) E78.4 (Other hyperlipidemia)

For ASCVD patients, MUST select appropriate code for Hypercholesterolemia AND ASVCD

Clinical ASCVD-specific code (s): _____

Lab Results: LDL-C _____ mg/ml **Result Date:** _____

Prior Therapy	Yes	No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Comorbidities: _____

Concomitant Medications: _____

Allergies: NKDA Other: _____

Prescription	Quantity	Refill
Praluent® (alirocumab) <input type="checkbox"/> Inject 75 mg SQ every 2 weeks <input type="checkbox"/> Inject 150 mg SQ every 2 weeks <input type="checkbox"/> Inject 300 mg SQ every 4 weeks	2 x 75 mg/mL 2 x 150 mg/mL	Pen _____
Repatha® (evolocumab) <input type="checkbox"/> Inject 140 mg SQ every 2 weeks <input type="checkbox"/> Inject 420 mg SQ every 4 weeks <input type="checkbox"/> Administer 420 mg SQ monthly	2 x 140 mg/mL 3 x 140 mg/mL 1 x 420 mg/3.5 mL	<input type="checkbox"/> SureClick® Autoinjector <input type="checkbox"/> PFS Pushtronex™ _____

Injection Training Provided by: Prescriber's Office CoxHealth at Home Other: _____

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home, and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.

