HOME PARENTERAL SERVICES

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Hypercholesterolemia

Patient 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 + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ❑ First Fill ❑ Always Never

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

Diagnosis: ❑ E78.0 (Pure hypercholesterolemia) ❑ E78.2 (Mixed hyperlipidemia) ❑ E78.4 (Oher 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)	❑ Inject 75 mg subq every 2 weeks	2 x 75 mg/mL	Pen	_____
	❑ Inject 150 mg subq every 2 weeks	2 x 150 mg/mL		
Repatha ® (evolocumab)	❑ Inject 140 mg subq every 2 weeks	2 x 140 mg/mL	❑ SureClick® Autoinjector	_____
	❑ Inject 420 mg subq every 4 weeks	3 x 140 mg/mL	❑ PFS	
	❑ Administer 420 mg subq via on-body infusor over 9 minutes	1 x 420 mg/3.5 mL	Pushtronex ™	_____

Injection Training Provided by: ❑ Prescriber's Office ❑ HPS Other: _____

Prescriber's Signature: _____ _____ Date: _____

Substitution Permitted Dispense as Written

I authorize Home Parenteral Services. 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 Home Parenteral Services.

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