PHONE: 1-855-419-4663
FAX: 1-417-269-0692

CoxHealth at Home

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

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 ❑ Inject 300 mg subq every 4 weeks	2 x 150 mg/mL		
Repatha ® (evolocumab)	❑ Inject 140 mg subq every 2 weeks	2 x 140 mg/mL	❑ SureClick® Autoinjector ❑ PFS	_____
	❑ Inject 420 mg subq every 4 weeks	3 x 140 mg/mL		
	❑ 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 ❑ 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.

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