PCSK9 INHIBITOR ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.WellDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

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

Best Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell Email: _____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

MEDICAL ASSESSMENT

For ASCVD patients, MUST select appropriate code for hypercholesterolemia AND ASCVD Clinical ASCVD (check all that apply)

Ischemic Heart Disease

- ☐ I21.3 ST elevation (STEMI) myocardial infarction of unspecified site
- ☐ I24.8 Other forms of acute ischemic heart disease
- ☐ I25.89 Other forms of chronic ischemic heart disease
- ☐ I25.2 Old myocardial infarction
- ☐ I20.9 Angina pectoris, unspecified
- ☐ I25.89 Other forms of chronic ischemic heart disease

Cerebrovascular and Peripheral Vascular Disease

- ☐ I65.8 Occlusion and stenosis of other pre-cerebral arteries
- ☐ I66.8 Occlusion and stenosis of other cerebral arteries
- ☐ G45.9 Transient cerebral ischemic attack, unspecified
- ☐ I69.998 Other sequelae following unspecified cerebrovascular disease
- ☐ I70.90 Unspecified atherosclerosis

Other ASCVD-specific code(s): _____

_____ 10 year ASCVD Risk %

Previous/Current Therapies:

☐ none	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ atorvastatin	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ ezetimibe	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ ezetimibe/ simvastatin	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ lovastatin	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ fenofibrate	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ gemfibrozil	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ niacin	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ pravastatin	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ rosuvastatin	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ rosuvastatin/ ezetimibe	_____ mg/day	_____ date	LDL-C _____	_____ date
☐ simvastatin	_____ mg/day	_____ date	LDL-C _____	_____ date

☐ Intolerance to statins (list medications and dose failed): _____

☐ Rhabdomyolysis ☐ Myositis ☐ Myalgia

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Repatha	☐ 140 mg/mL PFS ☐ 140 mg/mL SureClick ☐ 420 mg/3.5mL Pushtronix System	☐ Inject 140 mg sub-Q every 2 weeks ☐ Inject 420 mg sub-Q every 4 weeks	☐ 1 pack = 1 x 140 mg/mL PFS ☐ 1 pack = 1 x 140 mg/mL SureClick ☐ 2 pack = 2 x 140 mg/mL SureClick ☐ 3 pack = 3 x 140 mg/mL	_____ _____ _____ _____
Praluent	☐ 75 MG/ML PEN ☐ 75 mg/mL PFS	☐ Inject 75 mg sub-Q every 2 weeks	1 Carton = 2 x 75 mg/ml	_____
	☐ 150 mg/mL Pen ☐ 150 mg/mL PFS	☐ Inject 150 mg sub-Q every 2 weeks	1 carton = 2 x 150 mg/mL	_____
Other: _____				_____

PRESCRIBER INFORMATION

INJECTION TRAINING: OFFICE TO COORDINATE WELLDYNE SPECIALTY TO COORDINATE

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that WellDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written