Hyperlipidemia Enrollment Form

PYRAMIDS PHARMACY WEBSTER

All our referral forms are available on our website.

www.pyramidspharmacy.com

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ ❑lbs. ❑kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

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

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____

ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis (ICD-10):

❑ E78.0 Pure Hypercholesterolemia

❑ E78.01 Familial Hypercholesterolemia

Type: ❑ HeFH ❑ HoFH

❑ E78.1 Pure Hyperglyceridemia

❑ E78.2 Mixed Hyperlipidemia

❑ E78.4 Other Hyperlipidemia

❑ E78.5 Hyperlipidemia, Unspecified

ASCVD ICD-10 (if applicable): _____

Current LDL-C Value: _____

Date of test: _____

Current statin therapy:

_____

_____

_____

Previously tried/failed therapies, dose, and dates:

❑ Atorvastatin: _____

❑ Ezetimibe: _____

❑ Pravastatin: _____

❑ Rosuvastatin: _____

❑ Simvastatin: _____

❑ Other: _____

Intolerable adverse events:

❑ Myalgia ❑ Myositis ❑ Rhabdomyolysis

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
❑ Praluent®	❑ 75 mg/mL Pen ❑ 150 mg/mL Pen	❑ Inject 75 mg subQ every 2 weeks. ❑ Inject 300 mg subQ every 4 weeks. ❑ Inject 150 mg subQ every 2 weeks.		
❑ Repatha®	❑ 140 mg/mL Prefilled Syringe ❑ 140 mg/mL SureClick® Autoinjector	❑ Inject 140 mg subQ every 2 weeks. ❑ Inject 420 mg, given as 3 consecutive injections within 30 minutes, subQ once monthly. ❑ Other: _____		
	❑ 420 mg/3.5 mL Single-Use Pushtronex® System	❑ Inject 420 mg subQ over 9 minutes using the on-body infusor once monthly.		

Deliver to: ❑Patient ❑Office ❑Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

❑Product Substitution Permitted ❑Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____