CHOLESTEROL LOWERING AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PATIENT INFORMATION

Patient:_______________ Caregiver: _______________
DOB:_______________ ☐ Male or ☐ Female Weight:________ ☐ kgs or ☐ lbs (check one) Allergies:_______________
Address:_______________ City:_______________ State:__________ Zip:__________
Primary Phone #:_______________ ☐ Cell Alternate Phone #:_______________ ☐ Cell
Email:_______________

CLINICAL INFORMATION

Diagnosis/ICD-10:

Hypercholesterolemia (MUST select at least one)
__ E78.0 Pure hypercholesterolemia
__ E78.2 Mixed hyperlipidemia
__ E78.4 Other hyperlipidemia

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 unspecifi ed 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
___ fenofibate	____ 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
___ simvastatin	____ mg/day	______ date	LDL-C ______	______ date
___ Intolerance to statins (list medications and dose failed): _______________				
___ Rhabdomyolysis ___ Myositis ___ Myalgia				
___ Baseline LFT's: _______________				

PRESCRIPTION INFORMATION

Drug	Strength	Directions	Quantity	Refills
☐ Repatha®	___ 140 mg/mL Prefilled Syringe ___ 140 mg/mL SureClick	___ Inject 140 mg Sub-Q every 2 weeks ___ Inject 420 mg Sub-Q every 4 weeks	___ 1 pack = 1 x 140 mg/mL Prefilled Syringe ___ 1 pack = 1 x 140 mg/mL SureClick ___ 2 pack = 2 x 140 mg/mL SureClick ___ 3 pack = 3 x 140 mg/mL	**Refills:** _______ **Refills:** _______ **Refills:** _______ **Refills:** _______
☐ Praluent®	___ 75 mg/mL Pen ___ 75 mg/mL Prefilled Syringe ___ 150 mg/mL Pen ___ 150 mg/mL Prefilled Syringe	___ Inject 75 mg Sub-Q every 2 weeks ___ Inject 150 mg Sub-Q every 2 weeks	1 Carton = 2 x 75 mg/mL 1 Carton = 2 x 150 mg/mL	**Refills:** _______ **Refills:** _______

PRESCRIBER INFORMATION

Anticipated Start Date: _______________ Prescriber Specialty: _______________
Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_______________
Prescriber: _______________ NPI #: _______________ Phone #: _______________
Fax #: _______________Contact Name: _______________
Office Address: _______________ City: _______________ State: _____ Zip: ________

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: _______________ Date: _______________

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