HYPERCHOLESTEROLEMIA

www.medboxrx.com

Med Box

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PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female

Address:

Phone: Alternate Phone:

Height: Weight: Insurance Information: ☐ Attached

Allergies:

Comorbidities: ☐ Ship to office ☐ Ship 1st order to office, subsequent orders to patient ☐ Ship to patient

DIAGNOSTICS

Date of diagnosis:_____

Hypercholesterolemia

- ☐ E78.0 Pure hypercholesterolemia
- ☐ E78.2 Mixed hypercholesterolemia
- ☐ E78.5 Other hypercholesterolemia

Diabetes

E10 Type 1 diabetes mellitus
E11 Type 2 diabetes mellitus
E66.9 Obesity, unspecified

Clinical ASCVD / Diabetes -specific code(s) _____

For ASCVD patients, select hypercholesterolemia code AND ASVCD code

Family history of ASCVD: _____

Other notes: _____

Previous/Current Therapies

☐ atorvastatin	_____	mg/day	date(s)	_____
☐ ezetimibe	_____	mg/day	date(s)	_____
☐ ezetimibe/simvastatin	_____	mg/day	date(s)	_____
☐ pravastatin	_____	mg/day	date(s)	_____
☐ rosuvastatin	_____	mg/day	date(s)	_____
☐ simvastatin	_____	mg/day	date(s)	_____
☐ other:	_____	mg/day	date(s)	_____

Lab Result (Most Recent):
LDL-C _____ mg/ml
Result Date: _____

Highest untreated LDL (if available)
LDL-C _____ mg/ml
Result Date: _____

Failure to any therapies above?: ☐ Yes ☐ No

Contraindications to therapies above?: ☐ Yes ☐ No

Details: _____

INJECT TRAINING

☐ Patient received Injection training ☐ Prescriber's office to provide injection training ☐ ABD to coordinate injection training

DRUG		DIRECTIONS	QUANTITY	REFILLS
☐ **Praluent®**	☐ 75 mg/mL Pen ☐ 75 mg/mL PFS	Inject 75 mg SQ every two (2) weeks		
	☐ 150 mg/mL Pen ☐ 75 mg/mL PFS	Inject 150 mg SQ every two (2) weeks		
☐ **Repatha®**	☐ 140 mg/mL PFS ☐ 140 mg/mL SureClick®	Inject 140mg SQ every two (2) weeks Inject 240mg SQ every four (4) weeks		
☐ **Vascepa®**	4 Grams taken daily with food	Four 0.5GM capsules BID Two 1GM capsules BID		

Other _____ **Sig:** _____ **Qty:** _____ **Refills**___

SIGNATURE		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified

By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.