UnityPoint at Home

SPECIALTY PHARMACY
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

PCSK9 REFERRAL

PATIENT INFORMATION

Please send a copy of ALL of patient's Prescription, Primary and Secondary insurance cards (both sides)
Also include any other beneficial information for prior authorization and dispensing assessments.

Patient Name _____ **DOB** _____ **Gender** ☐ Male ☐ Female

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work phone** _____ **Email** _____

Primary Language ☐ English ☐ Spanish ☐ Other specify _____ **Allergies** _____

RX Member ID _____ **RX Group ID** _____ **RX PCN** _____ **RX BIN** _____

DIAGNOSIS

☐ Homozygous Familial Hypercholesterolemia
- Is there genetic confirmation of 2 mutations in the LDL Receptor, ApoB, PCSK9, or LDL receptor Adaptor Protein 1? ☐ Yes ☐ No
- Did the patient have xanthoma before 10 years of age? ☐ Yes ☐ No
- Is there evidence of heterozygous familial hypercholesterolemia in both parents? ☐ Yes ☐ No

☐ Primary Hyperlipidemia (sub type--*Atherosclerotic Cardiovascular Disease * Heterozygous Familial Hypercholesterolemia)
- Atherosclerotic Cardiovascular Disease ☐ Yes ☐ No
- Heterozygous Familial Hypercholesterolemia ☐ Yes ☐ No

☐ Other Diagnosis: _____ ICD-10 Code(s): _____

CARDIAC HISTORY: PLEASE PROVIDE CURRENT OFFICE NOTES AND LIPID PANELS IF THE PATIENT RECORDS ARE NOT IN EPIC.

Mark all that apply: ☐ Acute coronary syndromes ☐ Peripheral arterial disease ☐ History of MI ☐ Coronary or other arterial revascularization ☐ Stable or unstable angina ☐ Transient ischemic attack ☐ Stroke

MEDICATION	DATE(S)	MAX DOSE	OUTCOME (MARK ALL THAT APPLY)

Many policies require documented failure, contraindication, or intolerance of at least 2 different statin medications with or without the addition of Ezetimibe with documentation of lipids while on therapy and reason for discontinuation. Please provide dates for all that apply.

Atorvastatin			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Lovastatin			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Pitavastatin			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Pravastatin			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Rosuvastatin			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Simvastatin			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Ezetimibe			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Ezetimibe/ Simvastatin			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Alirocumab			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis
Evolocumab			☐ Documented contraindication ☐ Elevated CK ☐ Goal LDL not met ☐ Liver abnormalities ☐ Myalgias ☐ Myopathy ☐ Rhabdomyolysis

Has the patient received samples of PCSK9 ? ☐ Yes ☐ No: If yes please provide date patient started therapy: _____

PROVIDED PATIENT COUNSELING ON: (CHECK ALL THAT APPLY)

☐ Financial assistance programs ☐ Increased exercise ☐ Insurance approval process ☐ Lipid lowering diet ☐ Potential costs
☐ Smoking cessation/Not smoking ☐ Other _____

PRESCRIPTION

☐ Praluent™	75mg pen inject subcutaneously every 14 days	Dispense _____ Refills _____
☐ Praluent™	150mg pen inject subcutaneously every 14 days	Dispense _____ Refills _____
☐ Repatha Sureclick™	140 mg pen inject subcutaneously every 14 days	Dispense _____ Refills _____
☐ Repatha Pushtronex™	420 mg pen inject subcutaneously once monthly	Dispense _____ Refills _____

Prescriber's Signature: _____ NPI: _____ Phone: _____

Address: _____ City: _____ State: _____ Fax: _____