ahma (rx)

CARDIOVASCULAR

Toll free phone: 844.749.6628
Toll free fax: 888.966.0647

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:	Date of Birth:	☐ Male ☐ Female	
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:

Product Shipping Options: ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:

Prescriber Information

Practice Name:	Office Contact:		
Prescriber :	NPI:	DEA:	
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Primary Diagnosis/ICD-10:	Secondary Diagnosis/ICD-10:	
Has the diagnosis of ASCVD been confirmed by any of the following? *(select all that applies):* ☐ Patient has a history of clinical ASCVD ☐ Stroke ☐ Transient ischemic attack ☐ Acute coronary syndromes ☐ Stable or unstable angina ☐ Coronary or other arterial revascularization	Contraindications for statin therapy: ☐ Active liver disease ☐ Unexplained persistent elevation of serum transaminases ☐ Pregnancy	☐ Patient has a history of cutaneous or tendinous xanthoma before age 10
Evidence of heterozygous familial hypercholesterolemia in both parents? ☐ Yes ☐ No If yes, please provide all clinical/lab results that confirms diagnosis: ☐ Intolerant to statins ☐ Displays lack of adherence to hypercholesterolemia medications	Confirmed genetic mutation of the LDL receptor ApoB or PCSK9? ☐ Yes ☐ No If yes, please provide lab results.	

Prior Failed Medications:			
☐ Atorvastatin	_____ mg/day	dates:	Lab Results
☐ Ezetimibe	_____ mg/day	dates:	LDL-C: _____ mg/mL
☐ Ezetimibe/simvastatin	_____ mg/day	dates:	Result date: _____
☐ Pravastatin	_____ mg/day	dates:	AST: _____
☐ Rosuvastatin	_____ mg/day	dates:	ALT: _____
☐ Simvastatin	_____ mg/day	dates:	Creatine kinase: _____
☐ Pitavastatin	_____ mg/day	dates:	
☐ Other:	_____ mg/day	dates:	

Will the patient continue to receive high intensity statin therapy? ☐ Yes ☐ No	What other cardiovascular medications will the patient continue receiving? List all that apply:

Prescription Information

Medication	Dose	Directions	Quantity	Days Supply	Refills
☐ Praluent®	☐ 75 mg/mL prefilled pens ☐ 150 mg/mL prefilled pens	☐ Inject 75 mg sub -Q every 2 weeks ☐ Inject 150 mg sub -Q every 2 weeks ☐ Inject 300 mg sub-Q every 4 weeks	☐ 2 prefilled pens ☐ 6 prefilled pens	☐ 28 days ☐ 84 days	
☐ Repatha™	☐ 140 mg/mL prefilled syringe ☐ 140 mg/mL SureClick ®	☐ Inject 140 mg sub-Q every 2 weeks	☐ 2 prefilled syringe ☐ 2 SureClick® pen s ☐ 6 prefilled syringes ☐ 6 SureClick® pens	☐ 28 days ☐ 84 days	
	☐ 420 mg/mL PushTronex™	☐ Inject 420 mg sub -Q every 4 weeks	☐ 1 PushTronex™ system with prefilled cartridge ☐ 3 PushTronex™ system with prefilled cartridge	☐ 30 days ☐ 90 days	

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***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), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If 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

Prescriber Signature: _____ _____
Date

urac ACCREDITED Specialty Pharmacy