

Patient Information						Please Fax a Copy of Patient's Insurance Card (Front and Back)			
Last Name		First Name		Home Phone		Work/Mobile Phone			
Home Address					City		State	ZIP	
Shipping Address (if different from above)					City		State	ZIP	
Social Security Number		Gender (M/F)	Date of Birth	Primary Caregiver Name and Phone			Emergency Contact Name and Phone		

Clinical Assessment		Please FAX recent clinical notes, labs, tests, with the prescription to expedite the Prior Authorization process							
Diagnosis									
ICD-9 Codes: <input type="checkbox"/> 272.0 (Pure Hypercholesterolemia) <input type="checkbox"/> 272.2 (Mixed Hyperlipidemia) <input type="checkbox"/> 272.4 (Other Hyperlipidemia)									
ICD-10 Codes: (When implemented, use ICD-10 codes)									
<input type="checkbox"/> E78.0 (Pure Hypercholesterolemia) <input type="checkbox"/> E78.2 (Mixed Hyperlipidemia) <input type="checkbox"/> E78.4 (Other Hyperlipidemia) <input type="checkbox"/> E78.5 (Unspecified Hyperlipidemia)									
ASCVD-Specific Code (ICD-9/ICD-10): _____ <small>For clinical ASCVD patients, please select the appropriate ICD code for hypercholesterolemia AND include the specific ASCVD diagnosis code.</small>									
Previous Lipid-Lowering Treatments: <input type="checkbox"/> None <input type="checkbox"/> Yes (Check all that apply)					Other Lipid-Lowering Agents to be Used Concurrently with PCSK9 Treatment:				
		Strength/Freq		Dates of Therapy		<input type="checkbox"/> None <input type="checkbox"/> Yes (Please indicate below): _____ _____ _____			
<input type="checkbox"/> atorvastatin	_____ mg/ _____	mm/yy _____ to _____							
<input type="checkbox"/> ezetimibe	_____ mg/ _____	mm/yy _____ to _____							
<input type="checkbox"/> pravastatin	_____ mg/ _____	mm/yy _____ to _____							
<input type="checkbox"/> rosuvastatin	_____ mg/ _____	mm/yy _____ to _____							
<input type="checkbox"/> simvastatin	_____ mg/ _____	mm/yy _____ to _____							
<input type="checkbox"/> Other: _____	_____ mg/ _____	mm/yy _____ to _____							
Is the patient statin intolerant? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe intolerance: _____									
Any other contraindications to non-PCSK9 therapy for hypercholesterolemia? _____									
Lab Values: <input type="checkbox"/> LDL-C _____ mg/dL Date: _____ Drug Allergies: _____									
<input type="checkbox"/> Sharps container and alcohol pads to be provided as needed					<input type="checkbox"/> Injection training needed				

Medication	Dose/Strength	Directions for Use	Quantity	Refills
<input type="checkbox"/> Praluent* <input type="checkbox"/> Pre-filled Pen <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> 75 mg/ml 2-Pack <input type="checkbox"/> 150 mg/ml 2-Pack	<input type="checkbox"/> Inject 75 mg SQ every 2 weeks <input type="checkbox"/> Inject 150 mg SQ every 2 weeks	28 days	

Prescriber/Shipping Information						*Indicates Required Field	
Practice/Facility Name		Physician First and Last Name*		Phone*		Fax	
Address*			City*		State*	ZIP*	
Physician NPI**		Nurse/Key Contact		Phone or Pager Number		Email	
Date Shipment Needed:		Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Other/Special Instructions:				Nurse Training Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Physician Signature: _____ DAW (Dispense as Written) **Date:** ____/____/____
 I authorize Hy-Vee Pharmacy Solutions and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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