Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

HYPERCHOLESTEROLEMIA ENROLLMENT FORM

Today's Date: ____________________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**______________ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ________________________ ☐ Male ☐ Female DOB:_____________________
Patient's First Name: ____________________________ Patient's Last Name: ______________________________
Address: ______________________________________ City: ______________________ State: _____ ZIP: _______________
Best Phone Number: ________________________________ Alternate Phone Number: ______________________________
Best E-mail Address: ____
Height:__________ Weight: ____________ ☐ kgs. or ☐ lbs. Recorded Date: ____________________
Caregiver: ____ Allergies: _________________________________
Store Preference (address): ____
Emergency Contact Name: __________________________ Emergency Contact Phone #: ________________________

Insurance Information: Please fax copy of insurance card (front + back)

If you are not a cardiologist, did you consult with a cardiologist or other specialist?
☐ **Yes** ☐ **No** **Name of Specialist & Specialty** ____

Clinical Informtion

Diagnosis/ICD-10

Please provide one **primary** ICD-10-CM code
☐ E 78.0 Pure Hypercholesterolemia (Including HeFH and HoFH)
☐ E 78.2 Mixed Hyperlipidemia
☐ E 78.4 Other and Unspecified Hyperlipidemia

Please provide one **secondary** ICD-10-CM code
☐ _____ Acute myocardial infarction
☐ _____ Old myocardial infarction
☐ _____ Other and Unspecified Angina Pectoris
☐ _____ Other forms of chronic ischemic heart disease
☐ _____ ASCVD, Unspecified
☐ _____ Occlusion and Stenosis of Precerebral Arteries
☐ _____ Occlusion of Cerebral Arteries (CVA)
☐ _____ Transient Cerebral Ischemia (TIA)
☐ _____ Other and Ill-Defined Cerebrovascular Disease
☐ _____ History of Stroke With Residuals
☐ _____ Atherosclerosis
☐ _____ Peripheral Vascular Disease, Unspecified

☐ Other (specify ICD-10-CM): ____________________________
____
____

☐ Will the patient remain on statin therapy ☐ Yes ☐ No

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ PRALUENT®	☐ 75 mg/mL Pen	Inject 75 mg sub-Q every 2 weeks	1 carton = 2 x 75 mg/mL	_____
	☐ 150 mg/mL Pen	Inject 150 mg sub-Q every 2 weeks	1 carton = 2 x 150 mg/mL	_____
☐ REPATHA™	☐ 140 mg/mL PFS	☐ Inject 140 mg sub-Q every 2 weeks	☐ 1 pack = 1 x 140 mg/mL PFS	_____
			☐ 1 pack = 2 x 140 mg/mL SureClick®	_____
	☐ 140 mg/mL SureClick®	☐ Inject 420 mg sub-Q every 4 weeks	☐ 2 pack = 4 x 140 mg/mL SureClick®	_____
			☐ 3 pack = 6 x 140 mg/mL SureClick®	_____

Prescriber Information

Date Prescription Needed: ____
Physician Name (please print): ______________________________ Contact Name: ____________________________
Phone #: ____________________ Fax #:______________________ NPI #: ________________ Tax ID#: __________
Office Address: ______________________________ City: __________________ State: _______ ZIP: ____________
State License #: _____________________________ DEA #: ______________________________________

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below. ____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: ____ **Date:** ________________