Giant Eagle Specialty Pharmacy

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

PRALUENT 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 Information

Diagnosis/ICD-10

Hypercholesterolemia (MUST select at least one)
☐ _____ (Pure Hypercholesterolemia, including HeFH)
☐ _____ (Mixed Hyperlipidemia)
☐ _____ (Other and Unspecified Hyperlipidemia)

For ASCVD patients, ***MUST*** select appropriate code for Hypercholesterolemia
AND ASCVD.

Clinical ASCVD (check all that apply)
Ischemic Heart Disease
☐ _____ Acute myocardial infarction
☐ _____ Other acute and subacute forms
☐ _____ Old myocardial infarction of ischemic heart disease
☐ _____ Angina pectoris
☐ _____ Other forms of chronic ischemic heart disease

Cerebrovascular and Peripheral Vascular Disease
☐ _____ Occlusion and stenosis of precerebral arteries
☐ _____ Occlusion of cerebral arteries
☐ _____ Transient cerebral ischemia
☐ _____ Late effects of cerebrovascular disease
☐ _____ Atherosclerosis

Other ASCVD-specific code(s) _____

☐ **Sharps container and alcohol pads to be provided as needed.**

Lab Value
☐ LDL-C _____ mg/dL
Date: _____

Medical Assessment

PRALUENT® (alirocumab) injection

☐ 75 mg/mL **Pen** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks
Qty: _____ Refill x: _____

☐ 150 mg/mL **Pen** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks
Qty: _____ Refill x: _____

☐ 75 mg/mL Pre-Filled **Syringe** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks
Qty: _____ Refill x: _____

☐ 150 mg/mL Pre-Filled **Syringe** 2-Pack
SIG: 1 mL subcutaneously every 2 weeks
Qty: _____ Refill x: _____

Drug Allergies: _____
☐ NKDA

Previous Or Current Lipid-Lowering Treatments

☐ None ☐ Yes (Check all that apply)

	Strength/Frq	Date
☐ atorvastatin	_____ mg/	_____
☐ ezetimibe	_____ mg/	_____
☐ pravastatin	_____ mg/	_____
☐ rosuvastatin	_____ mg/	_____
☐ simvastatin	_____ mg/	_____
☐ Other	_____ mg/	_____
☐ Other	_____ mg/	_____

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:** _____

For pharmacy use only: MyPraluent Fax 1-844-872-5447