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

REPATHA 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

Please provide one **primary** ICD-10-CM code
☐ _____ (Pure Hypercholesterolemia (Including HeFH and HoFH)
☐ _____ (Mixed Hyperlipidemia)
☐ _____ (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): _____

Prescription Information

Formulation and Directions
(Choose One):

☐ Inject 140-mg/mL subcutaneously using a SureClick® autoinjector every two (2) weeks†

Dispense: ☐ 28 days ☐ 84 days _____ days

Refills: _____

☐ Administer 420-mg/3.5 mL subcutaneously using a Pushtronex™ system (on-body infusor with prefilled cartridge) once (1) monthly‡

Dispense: ☐ 30 days ☐ 90 days _____ days

Refills: _____

Treatment History (dose in mg)

LDL-C on Treatment: _____ **Date:** _____

☐ Atorvastatin (Lipitor®)	☐ 10	☐ 20	☐ 40	☐ 80
☐ Rosuvastatin (Crestor®)	☐ 5	☐ 10	☐ 20	☐ 40
☐ Simvastatin (Zocor®)	☐ 5	☐ 10	☐ 20	☐ 40
☐ Ezetimibe (Zetia®)	☐ 10			

☐ Other statin/lipid-lowering medication(s): _____

Has the patient failed or do they have contraindications to any of the above therapies? _____

Other pertinent medical history or drug therapy: _____

Family history of atherosclerotic cardiovascular disease (ASCVD):

Allergies: _____

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: Repatha*Ready*™: 1-844-REPATHA (1-844-737-2842)