ABD
Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

HYPERCHOLESTEROLEMIA (PCSK9) ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female

Address:

Phone: Alternate Phone:

Height: Weight: Insurance Information: ☐ Attached

Allergies:

Comorbidities:

DIAGNOSIS

Date of diagnosis: _____

Hypercholesterolemia

☐ E78.0 Pure hypercholesterolemia
☐ E78.2 Mixed hypercholesterolemia
☐ E78.4 Other hypercholesterolemia

Clinical ASVD-specific code(s) _____

For ASCVD patients, select hypercholesterolemia code AND ASVCD code

Family history of ASCVD: _____

_____

Other notes: _____

_____

Previous / Current Therapies

☐ atorvastatin _____ mg/day date(s): _____
☐ ezetimibe _____ mg/day date(s): _____
☐ ezetimibe/simvastatin _____ mg/day date(s): _____
☐ pravastatin _____ mg/day date(s): _____
☐ rosuvastatin _____ mg/day date(s): _____
☐ simvastatin _____ mg/day date(s): _____
☐ other: _____ mg/day date(s): _____

Lab Results (Most Recent):
LDL-C _____mg/ml
Result Date: _____

Highest untreated LDL (if available):
LDL-C _____ mg/ml
Result Date: _____

Failure to any therapies above?: ☐ Yes ☐ No
Contraindications to therapies above?: ☐ Yes ☐ No
Details: _____

_____

INJECTION TRAINING

☐ **Patient received injection training** ☐ **Prescriber's office to provide injection training** ☐ **ABD to coordinate injection training**

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Praluent®**	☐ **75 mg/mL Pen** ☐ **150 mg/mL Pen**	Inject 1 pen SQ every two (2) weeks		
☐ **Repatha®**	☐ **140 mg/mL PFS** ☐ **140 mg/mL SureClick®**	☐ Inject 140 mg SQ every two (2) weeks		
	☐ **420 mg/3.5ml Pushtronix system**	☐ Inject 420 mg SQ every four (4) weeks		
☐ **OTHER:**				

☐ Patient is ready to start treatment, contact patient for delivery
☐ Ship all orders to office
☐ Ship first order to office, subsequent orders to patient

SIGNATURE		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified