Century Specialty Script

REPATHA & PRALUENT ENROLLMENT FORM

Fax: 877-521-5353 | **Phone: 800-521-3949**

PATIENT PROFILE

Patient Name		Phone #	
Address		SS #	
City		State	Zip
Date of Birth	Sex: □ M □ F	Height	Weight
Ship Med's to: □ Home	□ Work	□ MD Office	□ Other

INSURANCE INFORMATION*

Primary Insurance	ID#	**(*Please submit a front/back copy of the Prescription Drug Benefit Card.)**
Policy Holder	Group #	Policy #
Secondary Insurance (if applicable)		ID#
Policy Holder	Group #	Policy #

MEDICAL ASSESSMENT

Patient Treatment History

LDL-C on Treatment: _____

Date: _____

Drug	Strength (mg)
□ 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 medications:

_____

Does patient have contraindications or has patient failed any of the above therapies?

_____

Family history of atherosclerotic cardiovascular disease (ASCVD):

_____

_____

***** PLEASE PROVIDE SUPPORTING MEDICAL NOTES INCLUDING:**

(1) OFFICE NOTES

(2) DOCUMENTATION OF TRIED/FAILED STATIN THERAPY WITH AND WITHOUT ZETIA.

(3) COPY OF MOST RECENT LIPID PROFILE/PANEL.

DIAGNOSIS INFORMATION

Diagnosis Date: _____

Primary Diagnosis:

□ E78.0 Pure Hypercholesterolemia (HeFH & HoFH)
□ E78.2 Mixed Hyperlipidemia
□ E78.5 Other and Unspecified Hyperlipidemia
□ Other: _____

Secondary Diagnosis:

□ I21.__ Acute Myocardial Infarction
□ I25.2 Old Myocardial Infarction
□ I20.8 Other and Unspecified Angina Pectoris
□ I25.__ Other Forms of Chronic Ischemic Heart Disease
□ I25.10 ASCVD, Unspecified
□ I65.__ Occlusion and Stenosis of Precerebral Arteries
□ I6.__.___ Occlusion of Cerebral Arteries (CVA)
□ G45.__ Transient Cerebral Ischemia (TIA)
□ I67.__ Other and Ill-Defined Cerebrovascular Disease
□ I69.__ History of Stroke With Residuals
□ I70.__ Atherosclerosis
□ I73.9 Peripheral Vascular Disease, Unspecified

******* PLEASE AFFIX ACTUAL PRESCRIPTION HERE *******

PRESCRIPTION INFORMATION

REPATHA™ (evolocumab) injection 140mg/ml

Dosage/Strength: □ 140 mg/mL SureClick™ Subcutaneous Injection Every Two (2) Weeks

Days Supply: □ 30 Day □ 60 Day □ 90 Day □ Other: _____

Refill: _____

PRALUENT® (alirocumab) injection (75mg/ml & 150mg/ml)

Dosage/Strength: □ 75 mg/mL SureClick™ Subcutaneous Injection Every Two (2) Weeks
□ 150 mg/mL SureClick™ Subcutaneous Injection Every Two (2) Weeks

Days Supply: □ 30 Day □ 60 Day □ 90 Day □ Other: _____

Refill: _____

******* PLEASE AFFIX ACTUAL PRESCRIPTION HERE *******

PHYSICIAN INFORMATION

Physician:	**DEA#:**	**State License #:**	
NPI#:	**Contact:**		
Address:	**City/State/Zip:**	**Phone:**	**Fax:**

Physician Signature:_____ **Date:**_____

THIS IS A PATIENT ENROLLMENT FORM FOR THE ABOVE MENTIONED THERAPIES. PATIENTS HAVE THE RIGHT TO USE THE PHARMACY OF THEIR CHOICE. IF CENTURY SPECIALTY SCRIPT IS THE PATIENT'S CHOICE, PLEASE CALL-IN, FAX, OR MAIL PRESCRIPTIONS TO:

CENTURY SPECIALTY SCRIPT, 6 Fisher Avenue, Tuckahoe, NY 10707, 800-521-3949 (P), 877-521-5353 (F)