Hyperlipidemia
Patient Enrollment & Prescription Form

Tel: 844-443-6879 **Fax: 844-329-2447**

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Medina, Ohio.

PATIENT INFORMATION

Patient Name ______

DOB ___/___/______ SSN ______ Gender______

Weight ______ Height ______ Phone ______

Address ______

City, State, Zip ______

Cell Phone ______ E-Mail ______

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name ______

Insurance Co. Phone ______ Group# ______

Policy Holder Name ______

Policy Holder Employer ______

Relationship to Patient ______

ID# ______ RxBIN ______ PCN______

PRESCRIBER INFORMATION

Prescriber's Name ______

Practice Name ______

State License#______ UPIN ______

DEA ______ NPI ______

Address ______

City, State, Zip ______

Phone ______ Fax ______

Office Contact Person ______

Prescription Date ______ Date Needed ______

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber Signature ______

Ship to: ☐ Patient ☐ Prescriber's Office ☐ Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis (select all that apply) Date ___ / ___ / _____

☐ E78.0 - Pure Hypercholesterolemia, including HeFH or HoFH*

☐ E78.01 - Familial Hypercholesterolemia*

☐ E78.2 - Mixed Hyperlipidemia

☐ I25.10 - (ASCVD)

☐ E78.4 - Other Hyperlipidemia

☐ E78.5 - Unspecified Hyperlipidemia

** for HeFH - please include Dutch Lipid Clinic Network Score OR Genetic Test Results*

Current or previous therapy		Treatment Dates	Intolerant?	Not at Goal?
☐ Drug Name Crestor	Dose ______	___/___ to ___/_____	☐	☐
☐ Drug Name Lipitor	Dose ______	___/___ to ___/_____	☐	☐
☐ Drug Name ______	Dose ______	___/___ to ___/_____	☐	☐
☐ Drug Name ______	Dose ______	___/___ to ___/_____	☐	☐

Intolerance History (check all that apply): ☐ Rhabdomyolysis ☐ Myositis ☐ Myalgia ☐ Elevated LFT

Drug Allergies: ☐ NKDA ☐ ______ Latex Allergy? ☐ YES ☐ NO

Lipid Panel Results within previous 3 months: Date Measured: ___/___/_____

Total Cholesterol ______ LDL-C ______ HDL-C ______ Triglycerides ______ Non-HDL-C ______

Lab Test Results - ***Please attach relevant lab reports*** ***(LFT, CMP, CPK, etc.)***

Other concurrent medications: ______

Additional Comments: ______

PRESCRIPTION INFORMATION *(DAW requests must be handwritten)*

☐ **Praluent™ (alirocumab)** ☐ Pre-filled Pen ☐ 75mg ☐ 150mg

Directions: ☐ Inject subcutaneously once every 2 weeks as directed. QTY: 2 Refills ______

Directions: ☐ Inject 300mg subcutaneously once monthly as directed. QTY: 2 Refills ______

☐ **Repatha® (evolocumab)** ☐ 140mg SureClick® ☐ 420mg Pushtronex™ System

Directions: ☐ Inject 140mg subcutaneously every 2 weeks as directed. QTY: 2 Refills ____

Directions: ☐ Infuse 420mg over 9 minutes with infusor once monthly as directed. QTY: 1 Refills ____

Directions: ☐ Inject 420mg (3 pens consecutively within 30 minutes) once monthly as directed. QTY: 3 Refills ____

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.