Hyperlipidemia
Patient Enrollment & Prescription Form

Gentry HEALTH SERVICES
Together Creating a Path to Better Care

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

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, 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 _____
DEA _____ NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Office Contact Person _____
Office Contact EMAIL _____
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 ____