

**Patient Information – Please attach a copy of the patient’s insurance card**

Patient Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City:		State:	Zip:
Phone Number:		Alternate Phone Number:		Language:	
Allergies (Required):		<input type="checkbox"/> NKDA	Height:	Weight:	SSN:
Product Shipping Options: <input type="checkbox"/> Patient’s Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address:					

**Prescriber Information**

Practice Name:		Office Contact:			
Prescriber:		NPI:		DEA:	
Practice Address:		City:		State:	Zip:
Phone Number:		Fax Number:			

**Clinical Information – Please send all available chart notes including lab results**

Primary Diagnosis/ICD-10:		Secondary Diagnosis/ICD-10:			
Has the diagnosis of ASCVD been confirmed by any of the following? (select all that applies): <input type="checkbox"/> Intolerant to statins <input type="checkbox"/> Patient has a history of clinical ASCVD <input type="checkbox"/> Displays lack of adherence to hypercholesterolemia medications <input type="checkbox"/> Patient has a history of cutaneous or tendinous xanthoma before age 10 <input type="checkbox"/> Stroke <input type="checkbox"/> Transient ischemic attack <input type="checkbox"/> Acute coronary syndromes <input type="checkbox"/> Stable or unstable angina <input type="checkbox"/> Coronary or other arterial revascularization					Contraindications for statin therapy: <input type="checkbox"/> Active liver disease <input type="checkbox"/> Unexplained persistent elevation of serum transaminases <input type="checkbox"/> Pregnancy
Evidence of heterozygous familial hypercholesterolemia in both parents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide all clinical/lab results that confirms diagnosis:			Confirmed generic mutation of the LDL receptor ApoB or PCSK9? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide lab results.		
Prior Failed Medications: <input type="checkbox"/> Atorvastatin _____ mg/day _____ dates: <input type="checkbox"/> Ezetimibe _____ mg/day _____ dates: <input type="checkbox"/> Ezetimibe/simvastatin _____ mg/day _____ dates: <input type="checkbox"/> Pravastatin _____ mg/day _____ dates: <input type="checkbox"/> Rosuvastatin _____ mg/day _____ dates: <input type="checkbox"/> Simvastatin _____ mg/day _____ dates: <input type="checkbox"/> Pitavastatin _____ mg/day _____ dates: <input type="checkbox"/> Other: _____ mg/day _____ dates:		<u>Lab Results</u> LDL-C: _____ mg/mL Result date: _____ AST: _____ ALT: _____ Creatine kinase: _____			
Will the patient continue to receive high intensity statin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			What other cardiovascular medications will the patient continue receiving? List all that apply:		

**Prescription Information**

Medication	Dose	Directions	Quantity	Days Supply	Refills
<input type="checkbox"/> Praluent®	<input type="checkbox"/> 75 mg/mL prefilled syringe <input type="checkbox"/> 150 mg/mL prefilled syringe	<input type="checkbox"/> Inject 75 mg sub-Q every 2 weeks <input type="checkbox"/> Inject 150 mg sub-Q every 2 weeks <input type="checkbox"/> Inject 300 mg sub-Q every 4 weeks	<input type="checkbox"/> 2 prefilled syringes <input type="checkbox"/> 6 prefilled syringes	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	
<input type="checkbox"/> Repatha™	<input type="checkbox"/> 140 mg/mL prefilled syringe <input type="checkbox"/> 140 mg/mL SureClick®  <input type="checkbox"/> 420 mg/mL PushTronex™	<input type="checkbox"/> Inject 140 mg sub-Q every 2 weeks  <input type="checkbox"/> Inject 420 mg sub-Q every 4 weeks	<input type="checkbox"/> 2 prefilled syringe <input type="checkbox"/> 2 SureClick® pens <input type="checkbox"/> 6 prefilled syringes <input type="checkbox"/> 6 SureClick® pens <input type="checkbox"/> 1 PushTronex™ system with prefilled cartridge <input type="checkbox"/> 3 PushTronex™ system with prefilled cartridge	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days  <input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	

**Prescriber Signature and Date (Please sign and date below)**

\_\_\_\_\_ Date \_\_\_\_\_ Substitution Permissible \_\_\_\_\_ Date \_\_\_\_\_

Dispense as Written \_\_\_\_\_

Prescriber Specialty: \_\_\_\_\_

Check here to authorize Curexa™ and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber’s behalf. “I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge”