



### Cholesterol Enrollment Form

Phone: (706) 849-4161

Fax: (706) 798-9683

<b>PATIENT INFORMATION</b> (Complete or include demographic sheet) Patient Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Primary Phone: _____ Alternate Phone: _____ Gender: _____ Email: _____ SSN: _____ Allergies: _____	<b>PRESCRIBER INFORMATION</b> Prescriber Name: _____ State License #: _____ NPI#: _____ DEA#: _____ Organization: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Contact Person: _____ Tax ID: _____ Specialty: _____
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**INSURANCE INFORMATION:** Please fax/scan the front and back of the insurance card

**DIAGNOSIS AND CLINICAL INFORMATION** (Please fax recent clinical notes, labs, tests supporting information to expedite prior authorization process)

- New Start     
  Reauthorization     
  Continuation (new insurance)

**Primary ICD10 Code:** \_\_\_\_\_     
 **Secondary ICD10 Code/Diagnosis:** \_\_\_\_\_  
 C78.0 Pure Hypercholesterolemia (including HeFH and HoFH)  
 E78.2 Mixed Hyperlipidemia  
 E78.4 Other Hyperlipidemia  
 E78.5 Hyperlipidemia, unspecified

**Treatment History:**

LDL-C _____	Date (within 30 days): _____	Dates of Therapy: _____	Reason for discontinuation: _____
<input type="checkbox"/> Rosuvastatin	<input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40	_____	_____
<input type="checkbox"/> Atorvastatin	<input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80	_____	_____
<input type="checkbox"/> Pitavastatin	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 4	_____	_____
<input type="checkbox"/> Simvastatin	<input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40	_____	_____
<input type="checkbox"/> Pravastatin	<input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80	_____	_____
<input type="checkbox"/> Ezetimibe	<input type="checkbox"/> 10	_____	_____
<input type="checkbox"/> Other:	_____		

Attached active medication list for pharmacist review

**Delivery Options:**  Patient home     Office     Other (specify): \_\_\_\_\_

**Injection Training:** Expected date: \_\_\_\_\_  MD office  Barney's Specialty

	DOSE/STRENGTH	SIG	QTY	REF
Repatha	<input type="checkbox"/> 140mg/ml SureClick <input type="checkbox"/> 420mg/3.5ml Pushtronex	<input type="checkbox"/> Inject one syringe every two weeks <input type="checkbox"/> Inject one system every month	<input type="checkbox"/> 2 <input type="checkbox"/> 1	_____
Praluent	<input type="checkbox"/> 75mg/ml Pen <input type="checkbox"/> 150mg/ml Pen	<input type="checkbox"/> Inject one syringe every two weeks	<input type="checkbox"/> 2	_____

**Patient Support Program:** Please sign and date below to enroll in the pharmaceutical company assisted patient support programs and patient funding.

PATIENT SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*By signing this form and utilizing our services, you are authorizing Barney's Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.\*\*\*\*

X \_\_\_\_\_      X \_\_\_\_\_  
 Dispense as written/Date      Substitution Permitted/ Date

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.