Cholesterol Enrollment Form

Phone: (706) 849-4161 **Fax:** (706) 798-9683

PATIENT INFORMATION (Complete or include demographic sheet)	**PRESCRIBER INFORMATION**
Patient Name:_____ DOB:_____	Prescriber Name: _____
Address: _____	State License #: _____ NPI#: _____
City, State, Zip:_____	DEA#: _____
Primary Phone:_____	Organization:_____
Alternate Phone:_____ Gender:_____	Address:_____
Email:_____	City, State, Zip: _____
SSN:_____	Phone: _____ Fax: _____
Allergies:_____	Contact Person: _____ Tax ID: _____
	Specialty: _____

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:

□ C78.0 Pure Hypercholesterolemia (including HeFH and HoFH)
□ E78.2 Mixed Hyperlipidemia
□ E78.4 Other Hyperlipidemia
□ E78.5 Hyperlipidemia, unspecified

Secondary ICD10 Code/Diagnosis:

_____

Treatment History:

LDL-C _____ Date (within 30 days): _____

	Dates of Therapy:	Reason for discontinuation:
□ Rosuvastatin □ 5 □ 10 □ 20 □ 40	_____	_____
□ Atorvasttin □ 10 □ 20 □ 40 □ 80	_____	_____
□ Pitavastatin □ 1 □ 2 □ 4	_____	_____
□ Simvastatin □ 5 □ 10 □ 20 □ 40	_____	_____
□ Pravastatin □ 10 □ 20 □ 40 □ 80	_____	_____
□ Ezetimibe □ 10		
□ 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	□ 140mg/ml SureClick □ 420mg/3.5ml Pushtronex	□ Inject one syringe every two weeks □ Inject one system every month	□ 2 □ 1	_____
Praluent	□ 75mg/ml Pen □ 150mg/ml Pen	□ Inject one syringe every two weeks	□ 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