Parkway
SPECIALTY PHARMACY

Specialty Hyperlipidemia Enrollment Form

3502 U.S. Highway 9. Howell. N.J. 07731 | www.**parkwaysp**.com | Email: intake@parkwaysp.com | Phone: 1-866-355-7797 | Fax: 1-888-551-6289

PATIENT INFORMATION

Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Email:
SS #:	Primary Language:		Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

PRESCRIPTION INFORMATION

Needs by Date: **Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other**

Drug	Dose	Direction & Quantities	Refills
Repatha™	O SureClick autoinjector O Pre-filled Syringe	O Inject 140 mg SQ every 2 weeks (Quantity 2)	
	O Pushtronex® system	O Administer 420 mg SQ once monthly over 9 minutes by using the single-use on-body infusor with prefilled cartridge (Quantity: 1)	
Praluent®	O Pre-filled Pen O 75 mg/mL O 150 mg/mL	O Inject 75 mg SQ every 2 weeks (Quantity: 2) O Inject 150 mg SQ every 2 weeks (Quantity: 2) O Inject 300 mg SQ every 4 weeks (Quantity: 2) **To administer 300 mg, give two 150 mg injections consecutively at two different injection sites**	

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

PREVIOUS THERAPIES:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
O Lipitor *(atorvastatin calcium)*	O (_____)	O	_____
O Crestor *(rosuvastatin calcium)*	O (_____)	O	_____
O Zocor *(simvastatin)*	O (_____)	O	_____
O Livalo *(pitavastatin)*	O (_____)	O	_____
O Pravachol *(pravastatin sodium)*	O (_____)	O	_____
O Zetia *(ezetimibe)*	O (_____)	O	_____
O Vytorin *(ezetimibe/simvastatin)*	O (_____)	O	_____
O _____	O (_____)	O	_____
O _____	O (_____)	O	_____

Indicate one primary diagnosis:

- O E78.01 HeFH Pure Hypercholesterolemia
- O E78.0 HoFH Pure Hypercholesterolemia
- O E78.2 Mixed Hyperlipidemia
- O E78.4 Other Hyperlipidemia
- O E78.5 Hyperlipidemia, Unspecified
- O Other: _____

Indicate all applicable secondary diagnoses:

- O I20.0 Unstable Angina
- O I20.9 Angina Pectoris, Unspecified
- O I21. __ Acute Myocardial Infarction
- O I25. __ Other Forms of Chronic Ischemic Heart Disease
- O I25.10 ASCVD, Unspecified
- O I63.9 Cerebral Infarction, Unspecified (CVA)
- O I65.23 Occlusion & stenosis of bilateral carotid arteries
- O I67.9 Cerebrovascular disease, Unspecified
- O I70. __ Atherosclerosis
- O I73.9 Peripheral Artery/Vascular Disease, (PAD/PVD)
- O G45.9 Transient Cerebral Ischemic Attack (TIA)
- O Other: _____

Please attach a copy of the most recent lipid panel

Allergies: _____ Date of Diagnosis: ____/____/_____ Lab Results: LDL_____mg/dL Date:___/___/_____

Patient Height:_____ in/cm Weight: _____ kg/lbs

Additional Clinical Information:

PRESCRIBED BY OR IN CONSULTATION WITH:

O Cardiologist O Endocrinologist O Lipid Specialist

INJECTION TRAINING

O Patient has received pen and injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.