HOMETOWN PHARMACY
Specialty Care Program

HYPERCHOLESTEROLEMIA SPECIALTY CARE PROGRAM

Phone: **844-812-9397** • Fax: **855-414-4886**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Tax I.D.: _____

Office Contact: _____ Phone: _____

Specialty: ❑ Cardiology ❑ Lipidology ❑ Other _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation and Laboratory Results)

Date of Diagnosis: _____

Primary ICD-10: _____ Secondary ICD-10: _____

Other: _____

Contraindications:

Fibrates: ❑ Yes ❑ No Statin: ❑ Yes ❑ No Niacin: ❑ Yes ❑ No

If yes: ❑ Myopathy or Rhabdomylosis ❑ Hepatic Disease ❑ Renal Dysfunction

❑ Pregnancy or Lactation ❑ Recent Stroke or TIA ❑ Other _____

Laboratory Tests:

❑ Lipid Panel	❑ No ❑ Yes	Date: _____
❑ Liver Function	❑ No ❑ Yes	Date: _____
❑ Renal Function	❑ No ❑ Yes	Date: _____

Prior Failed Therapies:	**Indicate Drug Name and Length of Treatment:**
❑ Fibrates	_____
❑ Niacin	_____
❑ Omega-3	_____
❑ Statin	_____
❑ Other	_____

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review
❑ Send Preferred Formulary Alternatives

If labs must be obtained from another prescriber, please indicate name here: _____

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ PRALUENT™	❑ 75mg/ml Pre-filled Pen	❑ Inject 75mg SC every 2 weeks	2	
	❑ 150mg/ml Pre-filled Pen	❑ Inject 150mg SC every 2 weeks ❑ Inject 300mg SC once a month	2	
❑ REPATHA™	❑ 140mg/ml SureClick® Auto Injector	❑ Inject 140mg SC every 2 weeks	2	
		❑ Inject 420mg SC once a month *(Inject three 140mg/ml injections consecutively within 30 minutes)*	3	
	❑ 420mg/3.5ml Pushtronex® system	❑ Inject single use Pushtronex® system on body with prefilled cartridge	1 Pack	
❑ OTHER	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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