Repatha/Praluent Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

CARD23-01

PATIENT INFORMATION

Last Name	First Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Work Phone	Cell Phone

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes*

Patient New to Therapy ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date ____ /____ / ____

Height _____ in Weight _____ lb Date ____ /____ / ____ | Allergies ☐ NKDA ☐ Drug Allergies (please list)

Therapies Tried and Failed (please list name and dose)

Concomitant Medications (please list name and dose)

ICD-10 Code

☐ E78.0 HoFH Pure Hypercholesterolemia
☐ E78.01 HeFH Pure Hypercholesterolemia
☐ E78.2 Mixed Hyperlipidemia
☐ E78.4 Other Hyperlipidemia
☐ E78.5 Hyperlipidemia, unspecified
☐ Other

PRESCRIPTION – *please check all boxes across row*

Medication	Route	Dose/Strength/Directions	Quantity	Refills
☐ **PRALUENT® (alirocumab)**	☐ Pre-filled Pen 2-pack ☐ Pre-filled Syringe 2-pack	☐ Inject 75 mg every 2 weeks ☐ Inject 150 mg every 2 weeks ☐ Inject 300 mg every 4 weeks	☐ 1-month supply ☐ 3-month supply ☐ _____	☐ 1-year ☐ _____
☐ **REPATHA® (evolocumab)**	☐ 140 mg/mL single-use pre-filled SureClick® autoinjector ☐ 140 mg/mL pre-filled syringe ☐ 420 mg/3.5 mL single-use pre-filled Pushtronex on-body infusor	☐ Inject 140 mg subcutaneously every 2 weeks ☐ Inject 420 mg subcutaneously once a month	☐ 1-month supply ☐ 3-month supply ☐ _____	☐ 1-year ☐ _____

☐ **Enroll in Nurse Training / Manufacturer Program**

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA. ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic | Date Shipment Needed By: ____ /____ / ____