Dyslipidemia Medication Enrollment Form

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

DIAGNOSIS

Description / ICD-10 Code

- ☐ E78. _____ Hyperlipidemia
  - ☐ HeFH (Heterozygous)
    - ☐ Z83.42 Family History of Familial Hypercholesterolemia
  - ☐ HoFH (Homozygous)
- ☐ 12 ___ . _____ Ischemic Heart Disease
- ☐ 16 ___ . _____ Cerebrovascular Disease
- ☐ 170. _____ Atherosclerosis
- ☐ 173. _____ Other Peripheral Vascular Disease
- ☐ Other: _____

Secondary ICD-10

- ☐ E08. _____ Diabetes Mellitus due to underlying condition
- ☐ E13. _____ Other Specified Diabetes Mellitus
- ☐ I10 Hypertension
- ☐ I25. _____ Chronic Ischemic Heart Disease
- ☐ Other: _____

Ship To:

- ☐ Patient
- ☐ Physician/Clinic
- ☐ 1st dose to Physician/Clinic, remainding refills to patient

Injection Training Provided By:

- ☐ Prescriber's Office
- ☐ Specialty Pharmacy
- ☐ Manufacturer
- ☐ Other: _____

CLINICAL INFORMATION- *(Please attach all clinical infomation, lab results and other medical history documents)*

- ☐ Patient Demographics
- ☐ Prescription Card (Front & Back)
- ☐ Last 4 Digits of Social: _____
- ☐ Clinical Notes & Labs (including most recent lipid panel)
- ☐ Current LDL-C (winith last 6 months): _____mg/dl Date: _____
- ☐ Allergies: _____

Past Medical History Includes:

- ☐ Myocardial Infarction
- ☐ Stable or Unstable Angina
- ☐ Coronary/Arterial Revascularization
- ☐ Peripheral Arterial Disease
- ☐ Rhabdomyolysis
- ☐ Other: _____
- ☐ Intolerance to Statins (list medications failed): _____
- ☐ Rhabdomyolysis
- ☐ Myositis
- ☐ Myalgia
- ☐ Baseline LFT's: _____

Previous Treatment:

- ☐ Atorvastatin (Lipitor)
- ☐ Rosuvastatin (Crestor)
- ☐ Simvastatin (Zocor)
- ☐ Ezetimibe (Zetia)
- ☐ Other statin/lipid lowering agent(s): _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ LEQVIO	☐ 284mg PFS	Initiation: Inject 284mg SQ at Day 0, Month 3, then every 6 months Maintenance: Inject 284mg SQ every 6 months		
☐ PRALUENT	☐ 75mg/ml Pen ☐ 150mg/ml Pen	Inject ____ SQ every 2 weeks Inject 300mg (two 150mg injections) SQ every 4 weeks Other: _____	1 month supply Other: _____	
☐ REPATHA	☐ 140mg/ml Sureclick Pen ☐ 140mg/ml PFS ☐ 420mg/3.5ml Pushtronex	Inject ____ SQ every 2 weeks Inject 420mg SQ once monthly	1 month supply Other: _____	

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

By signing this formand utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers

Physician's Phone Number	Physician's NPI	Physician's Fax	Physician's Address
Prescriber Name/Group	Dispense as Written	Substitution Allowed	Date

V 6.28.23