

Send updates to: Fax: _____ Email: _____ Text: _____

Physician Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice Name / Supervising MD:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:
Policyholder Name:	Policyholder DOB:	BIN: PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	Primary Diagnosis: <input type="radio"/> Pure Hypercholesterolemia, Heterozygous FH (E78.0) <input type="radio"/> Pure Hypercholesterolemia, Homozygous FH (E78.0) <input type="radio"/> Hyperlipidemia, Mixed (E78.2)					
<input type="radio"/> Hyperlipidemia, Unspecified (E78.5)	Secondary Diagnosis: <input type="radio"/> Unstable Angina (I20.0) <input type="radio"/> Angina Pectoris, Unspecified (I20.9) <input type="radio"/> Acute MI (I21) <input type="radio"/> ASCVD without Angina (I25.10)					
<input type="radio"/> ASCVD with Unstable Angina (I25.110) <input type="radio"/> CABG (Z95.1) <input type="radio"/> Stroke (I63) <input type="radio"/> PVD (I73.9) <input type="radio"/> Carotid Artery Occlusion/Stenosis (I65.2) <input type="radio"/> TIA (G45.9) <input type="radio"/> Other (Specify ICD):						
TREATMENT ARRANGEMENTS:	Ship Meds: <input type="radio"/> Home <input type="radio"/> Doctor's Office	Start Date: / /	*Counseling and education provided by Meijer's Clinical Team			

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
<input type="radio"/> PRALUENT® (alirocumab) injection	<input type="radio"/> 75 mg/mL Pen <input type="radio"/> 75 mg/mL PFS	<input type="radio"/> Inject 75 mg sub-Q every 2 weeks	<input type="radio"/> 1 carton = 2 x 75 mg/mL	
	<input type="radio"/> 150 mg/mL Pen <input type="radio"/> 150 mg/mL PFS	<input type="radio"/> Inject 150 mg sub-Q every 2 weeks	<input type="radio"/> 1 carton = 2 x 150 mg/mL	
<input type="radio"/> REPATHA™ (evolocumab)	<input type="radio"/> 140 mg/mL PFS <input type="radio"/> 140 mg/mL SureClick®	<input type="radio"/> Inject 140 mg sub-Q every 2 weeks <input type="radio"/> Inject 420 mg sub-Q every 4 weeks	<input type="radio"/> 1 pack = 1 x 140 mg/mL PFS (Qty 2) <input type="radio"/> 2 pack = 2 x 140 mg/mL SureClick®	
	<input type="radio"/> 420mg/3.5mL	<input type="radio"/> Inject 420mg sub-Q over 9 minutes by using the single-use on-body infusor with prefilled cartridge every 4 weeks	<input type="radio"/> 1 Pushtronex	
<input type="radio"/> Other:				

Injection Training

<input type="radio"/> Patient received injection training	<input type="radio"/> Prescriber's office to provide injection training	<input type="radio"/> Meijer to coordinate injection training	<input type="radio"/> Patient to receive injection training at Meijer
---	---	---	---

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____	Date _____	Physician Signature: _____	Date _____
----------------------------	------------	----------------------------	------------

Substitution Permitted

Dispense as Written