Dyslipidemia Enrollment Form

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

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, remaining refills to patient

Injection Training Provided By:

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

CLINICAL INFORMATION- *(Please attach all clinical information, 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 (within the 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 and dose 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 form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

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