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	☐ Inject ____ SQ every 2 weeks	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

V 01.09.25

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