REPATHA® ENROLLMENT FORM

FocusRx
Positive Patient Outcomes

FAX REFERRAL TO: 1-888-801-0404

PHONE: 1-888-464-8987

Administration Location:
☐ Patient Home
☐ Prescriber Office
Date : _____

PATIENT INFORMATION
(Complete the following *or send patient demographic sheet*)

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS#: _____
Date of Birth: _____ Sex: M - F

INSURANCE INFORMATION
Primary Insurance/Prescription Card:
PLEASE FAX COPY OF INS CARD (front and back if available)
Secondary Insurance/Prescription Card:
PLEASE FAX COPY OF INS CARD (front and back if available)

DIAGNOSIS
☐ HeFH (Heterozygous familial hypercholesterolemia
☐ HoFH (Homozygous familial hypercholesterolemia)
☐ ASCVD (Atherosclerotic cardiovascular disease)
☐ Other: _____

PRESCRIBER INFORMATION

Name: _____
Practice Name: _____ Specialty:
Address: _____
City, State, Zip: _____
Office Phone: _____
Office Fax: _____
NPI#: _____
Key Office Contact: _____

CLINICAL INFORMATION

Weight: _____kg / lbs. Height: _____ inches

Allergies:_____
Previous Treatments

☐ Atovastatin (Lipitor)_____mg ☐ Ezetimibe (Zetia) _____mg
☐ Rosuvastatin (Crestor)____mg ☐ Other Statin:_____
☐ Simvistatin (Zocor) _____mg ☐ Treatment Dates_____-_____
☐ Has patient failed above, or are there contraindications for using above?

PRESCRIPTION

Repatha®	☐ Inject 140mg subcutaneously every 2 weeks ☐ Inject 420mg subcutaneously once a month	☐ 30 day supply	# of Refills

Clinical Criteria – Check ALL that Apply

☐ Diagnosis confirmed by ☐ LDL-R DNA sequence test, or ☐ APOB mutation analysis
☐ Patient has a Dutch Lipid Clinical Network Criteria score of ≥ 8 (Hecht)
☐ Patient meets Simon Broome diagnostic criteria for Definite Familial Hypercholesterolemia (HeFH)
☐ Baseline LDL-C level _____mg/dl Date: _____. Current LDL-C level _____mg/dl Date: _____ ≥ 100 mg/dl in the past 30 days? (Provide results)
☐ Documented 3 month prior therapy with at least 1 high intensity statin in combination with Zetia
☐ If NO prior Statin therapy or Less than 3 months of therapy, please note reason:

- ☐ *Adverse reaction experienced* while on a High, and Low intensity Statin with Zetia. Please select all that apply:
  - ☐ Intolerable muscle symptoms ≥ 2 weeks (Eg. Pain, weakness, cramps)
  - ☐ Patient has undergone ≥ 2 trials of Statin Re-challenges with reappearance of adverse symptoms (one included Atorvastatin or Rosuvastatin).
  - ☐ Creatinine Kinase (CK) levels > 10x upper normal limit and/or rhabdomyolysis with CK levels > 10,000 IU/L
- ☐ Patient had an *Inadequate response* to a high intensity statin, and has undergone 3 months prior therapy with at least **2** statins and Zetia
- ☐ Patient has a *Contraindication* to a high intensity Statin. Please select all that apply
  - ☐ Patient is currently pregnant, or may become pregnant
  - ☐ Patient is a nursing mother
  - ☐ Patient has active liver disease and unexplained persistent elevations in transaminase levels (Eg. ALT ≥ 3 times upper normal limit) AND
    *Documentation of transaminase elevated levels included, and secondary causes for such elevations have been ruled out.

Additional ASCVD Criteria

1. Documented Secondary diagnosis and/or other cardiovascular event (check all that apply)
   - ☐ Acute Coronary syndrome
   - ☐ Angina - please clarify: Stable / Unstable
   - ☐ Findings from CT angio or catheterization consistent with clinical ASCVD
   - ☐ Peripheral arterial disease presumed to be of atherosclerotic origin
   - ☐ Other forms of Chronic Ischemic Heart Disease
   - ☐ Occlusion of Cerebral Arteries (CVA)
   - ☐ Coronary or other arterial revascularization procedure (such as PTCA, CABG)
   - ☐ Myocardial Infarction - please clarify: Acute / Old / Other _____
   - ☐ TIA (Transient ischemic attack)
   - ☐ Other and Ill-defined Cerebrovascular disease
   - ☐ Peripheral vascular disease unspecified
   - ☐ History of stroke with residuals
   - ☐ Occlusion and Stenosis of Precerebral Arteries
   - ☐ Other (specify Icd-10)_____
2. At high risk for Atherosclerotic Cardiovascular disease (ASCVD) or cardiovascular event based on 10 year risk score used by One of the following tools:
   - ☐ ASCVD Pooled Cohort Risk Assessment – score ≥ 15%
   - ☐ Framingham Risk score ≥ 20%

Additional relevant clinical information?

_____
Prescriber Signature (Date)

☒ *I authorize Focus Rx staff or its representatives to act as an agent to initiate and execute any insurance company prior authorization or precertification on my behalf.*