

PATIENT INFORMATION	
Patient Name: _____ Patient SSN#: _____	
Address: _____ <small style="text-align: center;">Address, City, State, Zip Code</small>	
Phone #: _____ 2 nd Phone #: _____ Date of Birth: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Weight (lbs): _____ Height (in.): _____ Allergies: _____	
Primary Insurance: _____ Secondary Insurance: _____	
ID#: _____ Phone #: _____ ID#: _____ Phone #: _____	
FAX COPY OF INSURANCE CARD (FRONT & BACK)	

CLINICAL INFORMATION			
<p style="text-align: center;">ICD-10 Primary Diagnosis</p> <input type="checkbox"/> E78.0 Pure Hypercholesterolemia <input type="checkbox"/> E78.2 Mixed Hypertlipidemia* <input type="checkbox"/> E78.4 Other Hyperlipidemia* <input type="checkbox"/> E78.5 Hyperlipidemia, unspecified* <i>*Require secondary diagnosis</i> <p style="text-align: center;">ICD-10 Secondary Diagnosis</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> I20.0 Unstable Angina <input type="checkbox"/> I20.9 Angina Pectoris, Unspecified <input type="checkbox"/> I21.____ Acute Myocardial Infarction <input type="checkbox"/> I22.____ Subsequent Myocardial Infarction <input type="checkbox"/> I25.____ Chronic Ischemic Heart Disease <input type="checkbox"/> I63.____ Cerebral Infarction <input type="checkbox"/> I65.____ Occlusion and Stenosis of Cerebral Arteries, Extracranial </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> I66.____ Occlusion and Stenosis of Cerebral Arteries, Intracranial <input type="checkbox"/> I67.____ Other Cerebrovascular Diseases <input type="checkbox"/> I70.____ Atherosclerosis <input type="checkbox"/> I73.9 Peripheral Vascular Disease, Unspecified <input type="checkbox"/> G45.9 Transient Cerebral Ischemic Attack, Unspecified <input type="checkbox"/> G46.____ Vascular Syndromes </td> </tr> </table>	<input type="checkbox"/> I20.0 Unstable Angina <input type="checkbox"/> I20.9 Angina Pectoris, Unspecified <input type="checkbox"/> I21.____ Acute Myocardial Infarction <input type="checkbox"/> I22.____ Subsequent Myocardial Infarction <input type="checkbox"/> I25.____ Chronic Ischemic Heart Disease <input type="checkbox"/> I63.____ Cerebral Infarction <input type="checkbox"/> I65.____ Occlusion and Stenosis of Cerebral Arteries, Extracranial	<input type="checkbox"/> I66.____ Occlusion and Stenosis of Cerebral Arteries, Intracranial <input type="checkbox"/> I67.____ Other Cerebrovascular Diseases <input type="checkbox"/> I70.____ Atherosclerosis <input type="checkbox"/> I73.9 Peripheral Vascular Disease, Unspecified <input type="checkbox"/> G45.9 Transient Cerebral Ischemic Attack, Unspecified <input type="checkbox"/> G46.____ Vascular Syndromes	<p style="text-align: center;">Treatment History</p> <input type="checkbox"/> Atorvastatin(Lipitor®) _____ mg/day Date: _____ <input type="checkbox"/> Rosuvastatin(Crestor®) _____ mg/day Date: _____ <input type="checkbox"/> Simvastatin(Zocor®) _____ mg/day Date: _____ <input type="checkbox"/> Ezetimibe(Zetia®) _____ mg/day Date: _____ <input type="checkbox"/> Pravastatin _____ mg/day Date: _____ <input type="checkbox"/> Fenofibrate _____ mg/day Date: _____ <input type="checkbox"/> Gemfibrozil _____ mg/day Date: _____ Comorbidities: _____ Failure to treat due to: <input type="checkbox"/> LDL>100 despite diet & exercise regimen <input type="checkbox"/> Myalgias at high statin doses <input type="checkbox"/> Latex allergy <input type="checkbox"/> Pain at injection sites
<input type="checkbox"/> I20.0 Unstable Angina <input type="checkbox"/> I20.9 Angina Pectoris, Unspecified <input type="checkbox"/> I21.____ Acute Myocardial Infarction <input type="checkbox"/> I22.____ Subsequent Myocardial Infarction <input type="checkbox"/> I25.____ Chronic Ischemic Heart Disease <input type="checkbox"/> I63.____ Cerebral Infarction <input type="checkbox"/> I65.____ Occlusion and Stenosis of Cerebral Arteries, Extracranial	<input type="checkbox"/> I66.____ Occlusion and Stenosis of Cerebral Arteries, Intracranial <input type="checkbox"/> I67.____ Other Cerebrovascular Diseases <input type="checkbox"/> I70.____ Atherosclerosis <input type="checkbox"/> I73.9 Peripheral Vascular Disease, Unspecified <input type="checkbox"/> G45.9 Transient Cerebral Ischemic Attack, Unspecified <input type="checkbox"/> G46.____ Vascular Syndromes		
FAX COPY OF ALL RELATED CLINICAL/LAB INFO			
LDL-C on Treatment: _____ Date: _____	Dutch Scale Score: _____ Date conducted: _____		

MEDICATION RECONCILIATION		
1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> PRALUENT®	<input type="checkbox"/> 75 mg/mL Pen <input type="checkbox"/> 75 mg/mL PFS	Inject 75 mg subcutaneously every 2 weeks	1 carton = 2x75 mg/mL	
	<input type="checkbox"/> 150 mg/mL Pen <input type="checkbox"/> 150 mg/mL PFS	Inject 150 mg subcutaneously every 2 weeks	1 carton = 2x150 mg/mL	
<input type="checkbox"/> REPATHA™	<input type="checkbox"/> 140 mg/mL Pen <input type="checkbox"/> 140 mg/mL SureClick®	<input type="checkbox"/> Inject 140 mg subcutaneously every 2 weeks <input type="checkbox"/> Inject 420 mg subcutaneously every 4 weeks	<input type="checkbox"/> 1 pack = 1x140 mg/mL PFS <input type="checkbox"/> 1 pack = 2x140 mg/mL SureClick® <input type="checkbox"/> 2 pack = 4x140 mg/mL SureClick® <input type="checkbox"/> 3 pack = 6x140 mg/mL SureClick®	

Injection Training Provided By: Physician's Office Delta Drugs | Ship to: Physician's Office Patient's Home | Dispense As Written

PHYSICIAN INFORMATION	
Physician Name: _____ Contact: _____ NPI#: _____	
Address: _____ <small style="text-align: center;">Address, City, State, Zip Code</small>	
Phone #: _____ Fax#: _____ Email: _____	

Physician's Signature: _____ Date: _____

I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.