ISLAND DRUG Service Excellence Delivered Locally
SPECIALTY CARE

HYPERCHOLESTEROLEMIA SPECIALTY CARE PROGRAM

Phone: **855-254-7222** • Fax: **844-436-9127**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ______________________________

Address: ______________________________

City: ________________ State: ____ Zip: ________

Phone: ____________ Alt. Phone: ____________

Email: ______________________________

DOB: ________ Gender: ❍ M ❍ F Caregiver: ________

Height: ______ Weight: ______ Allergies: __________

2 PRESCRIBER INFORMATION:

Name: ______________________________

Address: ______________________________

City: ________________ State: ____ Zip: ________

Phone: ____________ Fax: ____________

NPI: ____________ DEA: ____________

Tax I.D.: ______________________________

Office Contact: ____________ Phone: ____________

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation and Laboratory Results)

Date of Diagnosis: ____________

Primary ICD-10: ____________ Secondary ICD-10: ____________

Other: ______________________________

Contraindications:

Fibrates: ❑ Yes ❑ No Statin: ❑ Yes ❑ No Niacin: ❑ Yes ❑ No

If yes: ❑ Myopathy or Rhabdomylosis ❑ Hepatic Disease ❑ Renal Dysfunction

❑ Pregnancy or Lactation ❑ Recent Stroke or TIA ❑ Other ____________

Laboratory Tests:

❑ Lipid Panel ❑ No ❑ Yes Date: ____________

❑ Liver Function ❑ No ❑ Yes Date: ____________

❑ Renal Function ❑ No ❑ Yes Date: ____________

If Prior Authorization is Denied:

❑ Automatically Draft Appeal for Review ❑ Send Formulary Preferred Alternatives

Prior Failed Therapies:	Indicate Drug Name and Length of Treatment:
❑ Fibrates	____________
❑ Niacin	____________
❑ Omega-3	____________
❑ Statin	____________
❑ Other	____________

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
❑ PRALUENT™	❑ 75mg/ml Pre-filled Pen ❑ 75mg/ml Pre-filled Syringe	❑ Inject 75mg SC every 2 weeks	2	
	❑ 150mg/ml Pre-filled Pen ❑ 150mg/ml Pre-filled Syringe	❑ Inject 150mg SC every 2 weeks	2	
❑ REPATHA™	❑ 140mg/ml Pre-filled Syringe ❑ 140mg/ml SureClick® Auto Injector	❑ Inject 140mg SC every 2 weeks		
		❑ Inject 420mg SC once a month *(Inject three 140mg/ml injections consecutively within 30 minutes)*		
❑ OTHER ____________	____________	____________		

5 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ____________________ Date: ________ Signature: ____________________ Date: ________

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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