DELTADRUGS

Hypercholesterolemia

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RESET FORM

PATIENT INFORMATION

Patient Name: _____ Patient SSN#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ 2nd Phone #: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Weight (lbs): _____ Height (in.): _____ Allergies: _____

Primary Insurance: _____ | Secondary Insurance: _____

ID#: _____ Phone #: _____ | ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Primary Diagnosis

❑ E78.0 Pure Hypercholesterolemia
❑ E78.2 Mixed Hyperlipidemia*
❑ E78.4 Other Hyperlipidemia*
❑ E78.5 Hyperlipidemia, unspecified*

**Require secondary diagnosis*

ICD-10 Secondary Diagnosis

❑ I20.0 Unstable Angina
❑ I20.9 Angina Pectoris, Unspecified
❑ I21.__ Acute Myocardial Infarction
❑ I22.__ Subsequent Myocardial Infarction
❑ I25.__ Chronic Ischemic Heart Disease
❑ I63.__ Cerebral Infarction
❑ I65.__ Occlusion and Stenosis of Cerebral Arteries, Extracranial
❑ I66.__ Occlusion and Stenosis of Cerebral Arteries, Intracranial
❑ I67.__ Other Cerebrovascular Diseases
❑ I70.__ Atherosclerosis
❑ I73.9 Peripheral Vascular Disease, Unspecified
❑ G45.9 Transient Cerebral Ischemic Attack, Unspecified
❑ G46.__ Vascular Syndromes

Treatment History

❑ Atorvastatin(Lipitor®) _____ mg/day Date: _____
❑ Rosuvastatin(Crestor®) _____ mg/day Date: _____
❑ Simvastatitn(Zocor®) _____ mg/day Date: _____
❑ Ezetimbe(Zetia®) _____ mg/day Date: _____
❑ Pravastatin _____ mg/day Date: _____
❑ Fenofibrate _____ mg/day Date: _____
❑ Gemfibrozil _____ mg/day Date: _____

Comorbidities: _____

Failure to treat due to:
❑ LDL>100 despite diet & exercise regimen ❑ Myalgias at high statin doses
❑ Latex allergy ❑ Pain at injection sites

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
❑ PRALUENT®	❑ 75 mg/mL Pen ❑ 75 mg/mL PFS	Inject 75 mg subcutaneously every 2 weeks	1 carton = 2x75 mg/mL	
	❑ 150 mg/mL Pen ❑ 150 mg/mL PFS	Inject 150 mg subcutaneously every 2 weeks	1 carton = 2x150 mg/mL	
❑ REPATHA™	❑ 140 mg/mL Pen ❑ 140 mg/mL SureClick®	❑ Inject 140 mg subcutaneously every 2 weeks ❑ Inject 420 mg subcutaneously every 4 weeks	❑ 1 pack = 1x140 mg/mL PFS ❑ 1 pack = 2x140 mg/mL SureClick® ❑ 2 pack = 4x140 mg/mL SureClick® ❑ 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: _____
Address, City, State, Zip Code

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.

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