

TEL: (716) 929-1000

1-800-809-4763

FAX: (716) 532-7360

For Independent Health Patients:

Fax: 716-631-9636 or 1-800-273-7397

**Patient information**

**Prescriber information**

Name:	Name:
IH ID number:	NPI:
Date of birth:	Office phone:
Request is for: <input type="checkbox"/> NEW THERAPY (check one) <input type="checkbox"/> CONTINUATION/DOSE INCREASE	Office fax:

**Diagnosis**

- Homozygous familial hypercholesterolemia (HoFH)
- Heterozygous familial hypercholesterolemia (HeFH)
- Established cardiovascular disease (ASCVD)
- Primary hypercholesterolemia

**Drug/dose requested**

- REPATHA 140 mg every 2 weeks
- REPATHA 420 mg once monthly

**ICD-10 code:** \_\_\_\_\_

**Current LDL-C:** \_\_\_\_\_ mg/dL

**Date of current LDL-C:** \_\_\_\_\_

**Statin therapy**

*(check all that apply and note whether the member has stopped the statin or is currently using it along with current daily dose)*

- rosuvastatin     failed (side effect)     failed (efficacy)     taking now (daily dose: \_\_\_\_\_ mg)
- atorvastatin     failed (side effect)     failed (efficacy)     taking now (daily dose: \_\_\_\_\_ mg)
- simvastatin     failed (side effect)     failed (efficacy)     taking now (daily dose: \_\_\_\_\_ mg)
- pravastatin     failed (side effect)     failed (efficacy)     taking now (daily dose: \_\_\_\_\_ mg)
- lovastatin     failed (side effect)     failed (efficacy)     taking now (daily dose: \_\_\_\_\_ mg)
- other     failed (side effect)     failed (efficacy)     taking now

**Prescriber signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*By signing and dating above, the prescriber attests that all information provided is accurate and verifiable via member records.*

***This document contains confidential information.***