



reliance|rxSM

Specialty Pharmacy Services You Can Relv On

PCSK9 inhibitor physician attestation form

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: (check one) | Office fax: |
| <input type="checkbox"/> NEW THERAPY | |
| <input type="checkbox"/> CONTINUATION/DOSE INCREASE | |

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
- PRALUENT 75 mg every 2 weeks
- PRALUENT 150 mg every 2 weeks
- PRALUENT 300 mg once every 4 weeks

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)

| | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> rosuvastatin | <input type="checkbox"/> failed (side effect) | <input type="checkbox"/> failed (efficacy) | <input type="checkbox"/> taking now (daily dose: _____ mg) |
| <input type="checkbox"/> atorvastatin | <input type="checkbox"/> failed (side effect) | <input type="checkbox"/> failed (efficacy) | <input type="checkbox"/> taking now (daily dose: _____ mg) |
| <input type="checkbox"/> simvastatin | <input type="checkbox"/> failed (side effect) | <input type="checkbox"/> failed (efficacy) | <input type="checkbox"/> taking now (daily dose: _____ mg) |
| <input type="checkbox"/> pravastatin | <input type="checkbox"/> failed (side effect) | <input type="checkbox"/> failed (efficacy) | <input type="checkbox"/> taking now (daily dose: _____ mg) |
| <input type="checkbox"/> lovastatin | <input type="checkbox"/> failed (side effect) | <input type="checkbox"/> failed (efficacy) | <input type="checkbox"/> taking now (daily dose: _____ mg) |
| <input type="checkbox"/> other | <input type="checkbox"/> failed (side effect) | <input type="checkbox"/> failed (efficacy) | <input type="checkbox"/> 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.