RED CROSS PHARMACY
Our Family Caring For Yours

HYPERCHOLESTEROLEMIA SPECIALTY CARE PROGRAM

Phone: **888-216-1949** • Fax: **888-977-1391**

Kloud Script™
Specialty Care *Redefined*

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
❑ 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:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to 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.