Home Infusion & Specialty Pharmacy
CHARTWELL℠

Praluent®, Repatha™ Form

Auth #: _____ Auth Dates: _____ ☐ UPMC prior auth form attached

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Alternate Phone #: _____

DOB: _____ Wt: _____ Caregiver/Emergency Contact: _____ Phone#: _____

Allergies: _____ Latex: ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Insured: _____ Insured: _____

Phone: _____ Phone: _____

Policy #: _____ Group #: _____ Policy #: _____ Group #: _____

IC10

Diagnosis: ☐ ☐ Other: _____

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
Praluent® (alirocumab)	☐75mg Prefilled Syringe Kit ☐75mg Pen Kit ☐150mg Prefilled Syringe Kit ☐150mg Pen Kit	☐ Inject 75 mg subcutaneously every 2 weeks ———————————————— ☐ Inject 150 mg subcutaneously every 2 weeks	#2 (28-day supply)	
Repatha™ (evolocumab)	☐140mg/1ml Sureclick	☐ Inject 140 mg subcutaneously every 2 weeks ———————————————— ☐ Inject 420 mg subcutaneously once monthly	#2 (28-day supply) ———————— #3 (28-day supply)	

Prescriber Information

Date Shipment Needed: _____ Ship to: ☐ Patient ☐ Physician/Clinic

Ship to Other: _____

Physician's Name (please print): _____

Office Contact Name: _____

Phone #: _____ Fax: _____

Office Address: _____ City: _____ State: _____ Zip: _____

Physician's Signature: _____

I authorize Chartwell Pennsylvania Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.