Praluent Enrollment Form

If an item does not apply, please note "N/A" on that line.
Fax with copies of insurance card(s), front and back, and appropriate information from patient's medical charts.

Praluent® (alirocumab) Injection 75mg/mL 150mg/mL

SECTION 1 - Coverage Support

Enexia Specialty

Fax referral to
718-360-9655
Or Call 718-556-0942

SECTION 2 - Patient Information

Patient Name _____ DOB _____ Sex ☐ M ☐ F
Street Address _____
City _____ State _____ ZIP _____ - _____
Contact/Caregiver _____
Preferred Patient Language _____

Preferred Phone _____ Alternate Phone _____
Best time to contact ☐ Morning ☐ Afternoon ☐ Evening
Voice mail message ☐ Preferred Phone ☐ Alternate Phone ☐ No Message
Text message ☐ Preferred Phone ☐ Alternate Phone ☐ No Message
Email _____
Preferred Contact ☐ Phone ☐ Text Message ☐ Email

I allow the above listed pharmacy to obtain any necessary clinical information to submit authorization for this claim.

Sign _____ _____
Patient Signature/Legal Representative* Date MM/DD/YYYY

_____
Relationship to Patient*

*If signed by someone other than the patient, please describe your authority to sign on behalf of the patient.

SECTION 3 - Insurance Information (please attach copies of front and back of medical and prescription cards)

PRIMARY INSURER
Insurer _____ ☐ No Insurance
Insurance Phone _____
Policy ID Number _____
Group Number _____

PRESCRIPTION DRUG INSURER
Insurer _____ ☐ No Insurance
Insurance Phone _____
Policy ID Number _____ Group Number _____
Rx BIN Number _____ Rx PCN Number _____

SECTION 4 - Prescriber And Rx Information

Prescriber Name _____
Site/Facility Name _____
Address _____
City _____ State _____ ZIP _____ - _____
Phone _____ Fax _____
Office Contact Name _____
Office Contact Email _____
Prescriber NPI # _____ State License # _____
Prescriber Specialty Area _____

Rx Information: PRALUENT® (alirocumab) injection
☐ 75 mg/mL Pre-Filled Pen 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____
☐ 150 mg/mL Pre-Filled Pen 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____
☐ 75 mg/mL Pre-Filled Syringe 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____
☐ 150 mg/mL Pre-Filled Syringe 2-Pack
SIG: 1 mL subcutaneously every 2 weeks Qty _____ Refills _____
Sharps container to be provided.
Drug Allergies _____ ☐ NKDA
NY State Prescribers: Please submit prescription on an original NY State prescription blank.

Sign _____ _____
Prescriber Signature (no stamps) (Dispense as Written) Date MM/DD/YYYY

Sign _____ _____
Prescriber Signature (no stamps) (Substitution Permitted) Date MM/DD/YYYY

☐ Check this box to initiate a benefits investigation without a patient signature in section 2. By checking this box, I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to reimbursement support programs such as MyPRALUENT and the Alliance for purposes of conducting an investigation of my patient's health insurance coverage benefits for PRALUENT.

My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate, and that therapy with PRALUENT is medically necessary. I understand that my patients' information provided to Regeneron Pharmaceuticals, Inc., Sanofi US, and their affiliates and agents (the "Alliance"), is for the use of MyPRALUENT solely to verify my patient's insurance coverage, to assess, if applicable, my patient's eligibility for patient assistance and other support programs, and to otherwise administer MyPRALUENT for the patient. I request MyPRALUENT to conduct a benefit investigation for my patient and authorize MyPRALUENT to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan; provided that if this prescription is not so designated, MyPRALUENT is authorized to transmit this prescription to a network pharmacy it selects, or to the pharmacy otherwise indicated. I consent to MyPRALUENT contacting me by fax, mail, or email to provide additional information about PRALUENT or MyPRALUENT, and that MyPRALUENT may revise, change, or terminate any program services at any time without notice to me.

* While you may select any specialty pharmacy for assistance, please note that individual specialty pharmacies may require their own intake forms in addition to the MyPRALUENT Enrollment Form.

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MyPraluent™ Enrollment Form

Patient Name _____ Prescriber Name _____ NPI# _____

SECTION 5 - Treatment Information

☐ New Start
☐ Reauthorization
☐ Continuation (new insurance)

ICD-10 Diagnosis Codes

Select at least one primary and one secondary ICD-10 code.
Include as many appropriate clinical ASCVD codes as necessary to support your patient's diagnosis.

Primary diagnosis (MUST select at least one).

☐ E7 8.0 (Pure Hypercholesterolemia, including HeFH)
☐ E78.2 (Mixed Hyperlipidemia)
☐ E78.4 (Other Hyperlipidemia)
☐ E78.5 (Unspecified Hyperlipidemia)

If E78.2, E78.4, or E78.5 is selected, select a secondary diagnosis code as applicable.

Please refer to the coding reference list provided with this form for specific ASCVD codes.

Arteriosclerotic Heart Disease	☐ I25. __	History of Ischemic Stroke	☐ I69. __
Acute Coronary Syndromes	☐ I23. __ ☐ I24. __	With Residuals	
Acute Myocardial Infarction (active)	☐ I21.__ ☐ I22. __	Atherosclerosis of Peripheral and	☐ I70. __
Coronary Revascularization	☐ Z95. __ ☐ Z98. __	Other Non-coronary, Non-cerebral Vessels	
Arteriosclerotic Cerebrovascular Disease Ischemic Stroke	☐ I65. __ ☐ I66. __ ☐ I67. __ ☐ I63. __	Peripheral Artery Revascularization	☐ Z95. __ ☐ Z98. __
Transient Ischemic Attack	☐ G45. __	Other	☐ ___.__ ☐ ___.__ ☐ ___.__

LDL-C Values:

Current LDL-C _____ mg/dL Date: mm/yy _____

Previous And/Or Current Lipid-Lowering Treatments (dose mg/day)

☐ None ☐ Yes (please indicate below)

	Dose	Start date	Stop date	Intolerant	Current
☐ atorvastatin				☐	☐
☐ pravastatin				☐	☐
☐ rosuvastatin				☐	☐
☐ simvastatin				☐	☐
☐ ezetimibe				☐	☐
☐ Other				☐	☐

Last date on lipid-lowering treatment: mm/dd/yyyy _____

Failure on or contraindications to any of the above therapies?

_____

_____

_____

☐ Consultation with specialist (e.g., cardiologist, lipidologist)

_____

History of ASCVD event

☐ None ☐ Yes (please indicate below)

Date: mm/yy _____

☐ Angina
☐ Myocardial Infarction
☐ Transient Ischemic Attack
☐ Percutaneous Transluminal Coronary Angioplasty
☐ Peripheral Artery Disease
☐ Stroke
☐ Coronary or Other Arterial Revascularization

Primary Care Provider Information

Primary Care Provider Name _____

Primary Care Provider Phone _____

SECTION 6 - Patient Education

☐ Clinical nursing support including product administration training

SECTION 7 - Household Income

(required if requesting MyPRALUENT™ Patient Assistance for uninsured patients or for patients who lack pharmacy benefit coverage)

Total Annual Household Income*

☐ $0 to $100,000

☐ Greater than $100,000

*Salary/wages, Social Security income, unemployment insurance benefits, disability income, any other income for the household.

To qualify for the MyPRALUENT Patient Assistance Program, I understand that I must not have confirmed insurance coverage for PRALUENT, and I must meet certain income and other eligibility requirements. MyPRALUENT may ask for proof of income at any time for the purpose of audit/verification. If requested, I agree to provide proof of income within thirty (30) days of the request.

Continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify MyPRALUENT if my insurance situation changes.

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