# Repatha*Ready*™ Intake Form

**Please see Repatha™ Indications and Important Safety Information on the last page.**
**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 to:** Skyemed Pharmacy at 800-432-6614

SKYEMED PHARMACY & INFUSION SERVICES

Pharmacy Phone: 866-778-8255
Pharmacy Fax: 800-432-6614
pharmacy@skyemed.com

## Patient Information

Patient Name*: _____
Street Address*: _____
City*: _____ State*: _____ Zip*: _____
Preferred Phone*: ( ) _____
Email Address: _____
Date of Birth*: _____
Social Security Number: _____

## Pharmacy Insurance Information

❑ Attach a copy of insurance card, front and back, **AND** provide:
Pharmacy Insurance ID #*: _____
Pharmacy Insurance Telephone*: ( ) _____

## Primary/Secondary Medical Insurance Information

(ONLY if Pharmacy Insurance Information is not available)

❑ Attach a copy of insurance card, front and back, **AND** provide:
Name of Insurer*: _____
Insurer Telephone: ( ) _____
Group Number: _____
Policy Number*: _____

## Patient Medical Information†

Please provide one **primary** ICD-10-CM code*†:

❑ E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)‡
❑ E78.2 Mixed Hyperlipidemia
❑ E78.4 Other Hyperlipidemia
❑ E78.5 Hyperlipidemia, Unspecified

Please provide one **secondary** ICD-10-CM code*†:

❑ I20.0 Unstable Angina
❑ I20.9 Angina Pectoris, Unspecified
❑ I21.__ Acute Myocardial Infarction
❑ I22.__ Subsequent Myocardial Infarction
❑ I25.__ Chronic Ischemic Heart Disease
❑ I63.__ Cerebral Infarction
❑ I65.__ Occlusion and Stenosis of Cerebral Arteries, Extracranial
❑ I66.__ Occlusion and Stenosis of Cerebral Arteries, Intracranial
❑ I67.__ Other Cerebrovascular Diseases
❑ I70.__ Atherosclerosis
❑ I73.9 Peripheral Vascular Disease, Unspecified
❑ G45.9 Transient Cerebral Ischemic Attack, Unspecified
❑ G46.__ Vascular Syndromes
❑ Other (specify ICD-10-CM):
_____
_____
_____
_____

## Treatment History (dose in mg)

**LDL-C on Treatment:** _____ **Date:** _____

❑ Atorvastatin (Lipitor®) ❑ 10 ❑ 20 ❑ 40 ❑ 80
❑ Rosuvastatin (Crestor®) ❑ 5 ❑ 10 ❑ 20 ❑ 40
❑ Simvastatin (Zocor®) ❑ 5 ❑ 10 ❑ 20 ❑ 40
❑ Ezetimibe (Zetia®) ❑ 10
❑ Other statin/lipid-lowering medication(s): _____
_____
❑ Achieved maximum tolerated statin dose?
Has the patient failed on or do they have contraindications to any of the above therapies? _____
_____
Other pertinent medical history or drug therapy: _____
_____
Family history of atherosclerotic cardiovascular disease (ASCVD):
_____
Allergies: _____

## Prescription Information

Product Name: Repatha™ (evolocumab)
Dosage/Strength: ❑ 140 mg/mL SureClick™ Subcutaneous Injection, Every Two Weeks
Days' Supply: ❑ 30 Day ❑ 90 Day ❑ Other: _____
Refill: _____

## Prescriber Information

Office Contact: _____
Email Address: _____
Prescriber Name*: _____
Specialty: _____
Office Name*: _____
Office Street Address*: _____
City*: _____ State*: _____ Zip*: _____
Telephone*: ( ) _____
Fax: ( ) _____
Prescriber NPI #*: _____

## Prescriber Signature

❑ I authorize Amgen and its agents 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

**Prescriber Signature** (no stamps) (Dispense as Written):
_____ **Date:** _____

**Prescriber Signature** (no stamps) (Substitution Permitted):
_____ **Date:** _____

*Required for processing.
†The sample diagnosis codes are informational and not intended to be directive or a guarantee of reimbursement, and include potential codes that would include FDA-approved indications for Repatha™. Other codes may be more appropriate given internal system guidelines, payor requirements, practice patterns, and the services rendered.
‡HeFH, heterozygous familial hypercholesterolemia; HoFH, homozygous familial hypercholesterolemia.

**Fax Completed Form and/or Copy of Insurance Card(s), Front and Back, to** Skyemed Pharmacy at 800-432-6614

Please see the next page for the **Repatha***Ready*™ Program Privacy Notice and Authorization which must be signed by the patient or his or her legal guardian.

SKYEMED PHARMACY & INFUSION SERVICES

Repatha™ (evolocumab) injection 140 mg/mL

## INDICATIONS AND IMPORTANT SAFETY INFORMATION

Repatha™ is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (CVD), who require additional lowering of low density lipoprotein cholesterol (LDL-C).

Repatha™ is indicated as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) for the treatment of patients with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C.

The effect of Repatha™ on cardiovascular morbidity and mortality has not been determined.

The safety and effectiveness of Repatha™ have not been established in pediatric patients with HoFH who are younger than 13 years old.

The safety and effectiveness of Repatha™ have not been established in pediatric patients with primary hyperlipidemia or HeFH.

**Contraindication:** Repatha™ is contraindicated in patients with a history of a serious hypersensitivity reaction to Repatha™.

**Allergic reactions:** Hypersensitivity reactions (e.g. rash, urticaria) have been reported in patients treated with Repatha™, including some that led to discontinuation of therapy. If signs or symptoms of serious allergic reactions occur, discontinue treatment with Repatha™, treat according to the standard of care, and monitor until signs and symptoms resolve.

**Adverse reactions:** The most common adverse reactions (> 5% of Repatha™-treated patients and more common than placebo) were: nasopharyngitis, upper respiratory tract infection, influenza, back pain, and injection site reactions.

In a 52-week trial, adverse reactions led to discontinuation of treatment in 2.2% of Repatha™-treated patients and 1% of placebo-treated patients. The most common adverse reaction that led to Repatha™ treatment discontinuation and occurred at a rate greater than placebo was myalgia (0.3% versus 0% for Repatha™ and placebo, respectively).

**Adverse reactions from a pool of the 52-week trial and seven 12-week trials:**
Local injection site reactions occurred in 3.2% and 3.0% of Repatha™-treated and placebo-treated patients, respectively. The most common injection site reactions were erythema, pain, and bruising. The proportions of patients who discontinued treatment due to local injection site reactions in Repatha™-treated patients and placebo-treated patients were 0.1% and 0%, respectively.

Allergic reactions occurred in 5.1% and 4.7% of Repatha™-treated and placebo-treated patients, respectively. The most common allergic reactions were rash (1.0% versus 0.5% for Repatha™ and placebo, respectively), eczema (0.4% versus 0.2%), erythema (0.4% versus 0.2%), and urticaria (0.4% versus 0.1%).

Neurocognitive events were reported in less than or equal to 0.2% in Repatha™-treated and placebo-treated patients.

In a pool of placebo- and active-controlled trials, as well as open-label extension studies that followed them, a total of 1988 patients treated with Repatha™ had at least one LDL-C value < 25 mg/dL. Changes to background lipid-altering therapy were not made in response to low LDL-C values, and Repatha™ dosing was not modified or interrupted on this basis. Although adverse consequences of very low LDL-C were not identified in these trials, the long-term effects of very low levels of LDL-C induced by Repatha™ are unknown.

Musculoskeletal adverse reactions were reported in 14.3% of Repatha™-treated patients and 12.8% of placebo-treated patients. The most common adverse reactions that occurred at a rate greater than placebo were back pain (3.2% versus 2.9% for Repatha™ and placebo, respectively), arthralgia (2.3% versus 2.2%), and myalgia (2.0% versus 1.8%).

**Homozygous familial hypercholesterolemia (HoFH):** In 49 patients with HoFH studied in a 12-week, double-blind, randomized, placebo-controlled trial, 33 patients received 420 mg of Repatha™ subcutaneously once monthly. The adverse reactions that occurred in at least two (6.1%) Repatha™-treated patients, and more frequently than in placebo-treated patients, included upper respiratory tract infection (9.1% versus 6.3%), influenza (9.1% versus 0%), gastroenteritis (6.1% versus 0%), and nasopharyngitis (6.1% versus 0%).

**Immunogenicity:** Repatha™ is a human monoclonal antibody. As with all therapeutic proteins, there is a potential for immunogenicity with Repatha™.

**Please see accompanying Full Prescribing Information.**

AMGEN

**Repatha*Ready*™ Patient ID #:** _____ **Physician NPI #:** _____

## Repatha*Ready*™ Program
## Privacy Notice and Authorization

SKYEMED PHARMACY & INFUSION SERVICES

*Continued from previous page.*

I understand that once I sign this Authorization I am agreeing to be contacted by Amgen by mail, email, and/or phone for any of the purposes stated in this Authorization and that such communications may include the use of prerecorded voice messages and autodial systems.

**My preferred method(s) of contact:**

❑ Email ❑ Phone ❑ Mail ❑ SMS/text (standard text message charges may apply from your wireless provider)

❑ I choose to allow Amgen to leave me a voice message and/or send me an SMS/text that refers to the program by name and may contain personal health information about my condition or treatment.

My signature below certifies that I have **read, understand, and agree** to the Privacy Notice and Patient Authorization to release my personal health information as described in full detail on the previous page.

Patient Name: _____

Name of Legal Guardian (if needed): _____

Patient Signature (or Legal Guardian): _____ Date: _____

## Repatha™ Patient Start Program
## Patient and Prescriber Certification

### Patient Certification

With my signature below, I certify that I understand that Repatha™ provided in response to this request is not to be billed, sold, purchased, or traded. I certify that my doctor has provided a prescription for continued therapy. I also certify that prior to this prescription, I have not been treated with Repatha™ (except with a sample supply), nor have I been prescribed Repatha™ previously by this or any other doctor.

Patient Signature: _____ Date: _____

### Prescriber Certification and Information

With my signature below, I authorize my patient to receive one or more months of Repatha™ free of charge through the Repatha™ Patient Start Program after an initial coverage denial. I certify that all information provided on this form is accurate and truthful. I certify that this prescription is consistent with the labeled indications for Repatha™. I understand that Repatha™ provided in response to this request is not to be billed for, sold, purchased, or traded, to the best of my knowledge. I certify that my Patient is new to Repatha™ meaning that he or she is not currently being treated with Repatha™ (except with a sample supply) and, to the best of my knowledge, has not previously been prescribed Repatha™.

Prescriber Signature (no stamps): _____ Date: _____

The Repatha™ Patient Start Program is not available in Massachusetts, Puerto Rico, or where prohibited by law.

Amgen and its contractors will not sell any of your Personal Health Information and will only use it for the purposes described in the Privacy Notice and Authorization.

Repatha™ (evolocumab) injection 140 mg/mL

# Repatha*Ready*™ Program
# Privacy Notice and Authorization

SKYEMED PHARMACY & INFUSION SERVICES

I authorize Amgen and its contractors ("Amgen") to use and/or disclose *my personal information* including my personal health information for the following purposes:

- To enroll me in and/or continue my participation in Amgen's Repatha*Ready*™ patient support program and/or any other Amgen-affiliated patient support services and related activities. For example, the option to join the Repatha™ (evolocumab) Sharps Mail-Back Program to receive sharps disposal containers, the Repatha™ Copay Card program if eligible, the Repatha™ Patient Start Program, reimbursement assistance programs, drug coverage verification, nurse educator services, and disease management support;
- To contact, upon my permission, my healthcare team (including my doctor and his team) and share with them some of my important health information;
- **To provide me with information and marketing materials relating to Amgen products and services, and/or my condition or treatment**; and/or
- To improve, develop, evaluate, and continue products, services, materials, and programs related to my condition or treatment.

I also authorize any healthcare providers, healthcare plans, pharmacies, pharmaceutical companies, laboratories, and/or their contractors ("Healthcare Providers") to disclose any of *my personal health information* to Amgen as requested by Amgen and as necessary for the purposes stated in this Authorization.

I understand that my personal health information includes any information, in electronic or physical form, in the possession of or derived from a healthcare provider, healthcare plan, pharmacy, pharmaceutical company, and/or contractor regarding: (1) my medical history, including my entire medical file and complete patient history; (2) my healthcare plans benefits; (3) limits or restrictions on payments covered by my healthcare plan policy; and/or (4) my health or my adherence to treatment.

## Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that Amgen may use my personal information, including my personal health information, for 10 years once I accept this Authorization or for a shorter time period if required by state law. I also understand that I can cancel this Authorization at any time by calling Amgen at 1-844-REPATHA. Once Amgen receives and processes my cancellation, it will not use my personal information going forward; however, I understand that canceling my Authorization will not affect the use of my personal information that occurred before my request was processed. I further understand that if a Healthcare Provider is disclosing my personal health information to Amgen on an ongoing basis as authorized herein, my cancellation with Amgen will only be effective with respect to any such Healthcare Providers once they actually receive notice of my cancellation from Amgen.

## No Effect on Treatment

I understand that I do not have to agree to the uses and disclosures of my personal information contained in this Notice and Authorization. I understand that Amgen, as well as Healthcare Providers, cannot require me, as a condition of receiving medications, prescription drugs, treatment, or other care, to agree to this Authorization. However, I also understand that Amgen cannot provide me with any of the Repatha*Ready*™ program services without my authorization, including but not limited to my enrollment or continued participation in patient support services. Under these circumstances, I may be responsible for the full costs of my treatment.

## Information Received From Healthcare Providers

I understand that when a Healthcare Provider discloses my personal health information to Amgen for the purposes contained in this Notice and Authorization, the personal health information disclosed may not be covered by any federal law relating to the use of my personal health information or how it is disclosed. There is no guarantee that my personal health information received by Amgen from a Healthcare Provider might not be released to a third party. I further understand that if a Healthcare Provider is disclosing my personal health information on an ongoing basis to Amgen, this Authorization only permits Healthcare Providers to do so for one year once I accept this Authorization or for a shorter time period if required by state law.

*Continued on the next page.*

Repatha™ (evolocumab) injection 140 mg/mL