medix infusion

Leqvio® Order Form
(inclisiran)

FAX TO: 866.746.3890

Patient Information

Patient Name: ______ DOB: ______ Phone: ______ Sex: M F Ht: ______ Wt: ______ lbs kg

Primary Language: ______ Allergies: ______

Patient Preferred Location: ______

INSURANCE INFORMATION: *Please attach copy of insurance card (front and back)*

Diagnosis

ICD 10 Code Required

E78.00 Pure hypercholesterolemia, unspecified
E78.011 Heterozygous familial hypercholesterolemia [HeFH]
E78.2 Mixed hyperlipidemia
E78.5 Hyperlipidemia, unspecified
E78.019 Familial hypercholesterolemia, unspecified
E78.49 Other hyperlipidemia
I25.10 Atherosclerotic Heart Disease (ASCVD)

Other: ______ ICD 10: ______

Infusion Orders

DIRECTIONS/DURATION

DOSE: 284 mg

INITIAL: First dose: Inject SubQ x 1 dose
Second dose at 3 months: Inject SubQ x 1 dose

MAINTENANCE: Inject SubQ every 6 months x 1 year

Is patient currently receiving therapy above from another facility? YES NO

If yes, Facility Name: ______
Date of last treatment: ______

PRE-MEDICATION ORDERS

No premeds ordered at this time
Acetaminophen 650mg PO
Diphenhydramine 25mg PO
Other: ______

LAB ORDERS

Labs to be drawn by: Medix Infusion Referring Physician
No labs ordered at this time Other: ______
LDL-C q ______ Lipid Panel q ______ LFTs q ______

Required Clinical Documentation

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

Clinical information, select all that apply:

For all diagnoses

The patient's LDL-C level is elevated despite treatment with maximally tolerated statin therapy
- Recent LDL-C level: ______ mg/dl; Date lab drawn: ______ *(Attach copy of paperwork)*

The patient is currently on statin therapy
Current statin therapy; Drug name: ______ Dosage: ______ Start Date or Length of Therapy: ______
Check box if patient is on Zetia® (ezetimibe) in addition to statin therapy

The patient is ***not*** currently on statin therapy and has documented intolerance or contraindication to statin therapy
Patient is statin intolerant (List failed statin therapies and reasons below)
Patient has a contraindication for statin therapy, specify: ______

The patient has been compliant with Lipid lowering drug therapy and lifestyle modifications

For HeFH only

HeFH confirmed by: Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein(LDLRAP1) gene ***(Attach copy of assessment)***
WHO/Dutch Lipid Clinic Network Score (DLCNS); Score: ______ ***(Attach copy of assessment)***
Other: ______

For ASCVD only:

History of clinical atherosclerotic cardiovascular disease includes one or more of the following: ***(Select all that apply)***

Acute coronary syndrome
Coronary artery disease (CAD)
History of myocardial infarction
Stable or unstable angina
Coronary or other arterial revascularization
Stroke
Transient ischemic attack (TIA)
Peripheral arterial disease (PAD
Other: ______

LAB RESULTS (required)

LDL cholesterol blood level

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

Medication: ______ Dates of Treatment: ______ Reason for D/C: ______
Medication: ______ Dates of Treatment: ______ Reason for D/C: ______

Patient has received dietary counseling related to hyperlipidemia and CV disease

Referring Physician Information

Prescriber Name: ______ Signature: ______
Date: ______ NPI #: ______ Specialty: ______
Supervising Physician: ______ (If Applicable)
Address: ______ City: ______ State: ______ Zip: ______
Contact Name: ______ Phone: ______ Fax: ______ Email: ______