Leqvio® Order Form
(inclisiran)

FAX TO: 866.746.3890

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Gender: _____

Ht: _____ Wt: _____ ☐ lbs ☐ kg Primary Language: _____

Allergies: _____ Patient Preferred Location: _____

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

*(Please note that any patient who carries Medicare Advantage, Federal BCBS, Anthem and United Healthcare insurance require "tried and failed" treatment with **Repatha** before receiving Leqvio)*

Diagnosis

ICD 10 Code Required

☐ E78.00 Pure hypercholesterolemia, unspecified
☐ E78.011 Heterozygous familial hypercholesterolemia [HeFH]
☐ E78.2 Mixed hyperlipidemia
☐ E78.5 Hyperlipidemia, unspecified
☐ E78.19 Familial hypercholesterolemia, unspecified
☐ E78.49 Other hyperlipidemia
☐ I25.10 Atherosclerotic Heart Disease (ASCVD)
Other: _____ ICD 10: _____

Medication Order

DIRECTIONS/DURATION

DOSE: 284 mg

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

MAINTENANCE: ☐ 284 mg SubQ every 6 months thereafter

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

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

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

REQUESTED ADD'L LAB ORDERS
_____
_____

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

Medix Infusion will collect all necessary labs if not included in referral documents

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

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

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

Referring Provider Information

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____