

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)

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

Medication Order

DIRECTIONS/DURATION

DOSE: 284 mg **INITIAL:** First dose: Inject SubQ x 1 dose **MAINTENANCE:** 284 mg SubQ every 6 months thereafter

Second dose at 3 months: Inject SubQ x 1 dose

Is patient currently receiving therapy above from another facility? If yes, Facility Name: _____

YES NO

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