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)*

*(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 ☐ 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: _____

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Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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

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