Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067

Office: 310-481-9944 Fax : 310-766-7001

REFERRAL
LEQVIO(inclisiran)

Date: ____________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS
☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

LEQVIO Injection*:

*(SELECT **ONE** OF THE FOLLOWING)*

___ **Dosing:** 284 mg subcutaneously Injection

*Frequency: initial dose, again at 3 months, then every 6 months Refills__________

Continuity of care to leqvio 284mg every 6 months Refills__________

☐ Other _____________

Physician Signature* ________________________________ **Date*(Order is Valid for One Year)**____________________

* NPI#________________

REQUIRED DIAGNOSIS:

heterozygous familial hypercholesterolemia (HeFH)

_____ clinical atherosclerotic cardiovascular disease (ASCVD)

_____ Other__________________________

Last Infusion/Injection Date: _____________

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Other

ORDERING PROVIDER

Signature **X** ____ Date _______________

Provider ______________________________ Phone_____________ Fax _______________