

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Marlton
127 Church Road
Suite 600
Marlton, NJ 08053



REFERRAL LEQVIO(inclisiran)

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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 _____