

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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)
<input type="checkbox"/> clinical atherosclerotic cardiovascular disease (ASCVD)
<input type="checkbox"/> Other _____
Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:
<input type="checkbox"/> Patient Demographics
<input type="checkbox"/> Insurance Card/Information
<input type="checkbox"/> Clinical/Progress Notes supporting DX
<input type="checkbox"/> Current Medication List and H&P
<input type="checkbox"/> Other

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____