

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



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*:

Dosing: 284 mg subcutaneously Injection

FREQUENCY:

____ **Initial dose**, then 3 months later then every 6 months x 1 dose

____ **Continuity of care** leqvio 284mg SubQ every 6 months x 1 year

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 and associated treatment plan
____ Labs, lipid panel
____ Current Medication List and H&P
____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____