Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION

Mission Medical

Office: 212-803-3339 Fax : 646-768-8600

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*:

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 _____