

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



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 _____