

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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
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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 _____