Fairfield
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Suite 204
Fairfield, CT 06824

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469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

ThrIVewell™ INFUSION

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

Mission Medical

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 _____

LEQVIO® (INCLISIRAN)

TRIED & FAILED / MEDICAL NECESSITY DOCUMENTATION FORM

PATIENT INFORMATION

Patient Name: _____

DOB: _____

ICD-10 Code: _____

MEDICATION HISTORY

Please check all medications the patient has tried, failed, discontinued, or been unable to tolerate.

STATINS

☐ **Atorvastatin (Lipitor)**

Dose: _____ **Dates Tried:** _____

☐ **Rosuvastatin (Crestor)**

Dose: _____ **Dates Tried:** _____

☐ **Simvastatin (Zocor)**

Dose: _____ Dates Tried: _____

☐ **Pravastatin (Pravachol)**

Dose: _____ Dates Tried: _____

☐ **Fluvastatin (Lescol)**

Dose: _____ Dates Tried: _____

☐ **Pitavastatin (Livalo)**

Dose: _____ Dates Tried: _____

☐ **Other Statin: _____**

Dose: _____ Dates Tried: _____

NON-STATIN THERAPIES

☐ **Ezetimibe (Zetia)**

Dose: _____ Dates Tried: _____

☐ **Ezetimibe/Simvastatin (Vytorin)**

Dose: _____ Dates Tried: _____

☐ **Bempedoic Acid (Nexletol/Nexlizet)**

Dose: _____ Dates Tried: _____

☐ **Alirocumab (Praluent)**

Dose: _____ Dates Tried: _____

☐ **Evolocumab (Repatha)**

Dose: _____ Dates Tried: _____

☐ **Other: _____**

Dose: _____ Dates Tried: _____

REASON FOR FAILURE / DISCONTINUATION

Check all that apply:

☐ **Inadequate LDL-C reduction / inadequate therapeutic response**

☐ **Medication intolerance**

☐ **Adverse effects**

☐ **Myalgias / muscle pain**

☐ **Muscle weakness**

☐ **Elevated liver enzymes**

☐ **Gastrointestinal adverse effects**

☐ **Allergic reaction**

☐ **Drug interaction**

☐ **Contraindication**

☐ **Unable to achieve LDL-C goal despite therapy**

☐ **Unable to tolerate recommended dose**

☐ **Other: _____**

DETAILS / CLINICAL NOTES

CLINICAL RATIONALE FOR LEQVIO

Please describe the patient's treatment history and the clinical rationale for requesting Leqvio (inclisiran).

☐ Leqvio is being requested as an addition to the patient's current lipid-lowering therapy.

☐ Patient has demonstrated inadequate response to prior lipid-lowering therapy.

☐ Patient has demonstrated intolerance to prior lipid-lowering therapy.

☐ Other clinical rationale:

PROVIDER ATTESTATION

I attest that the medication history and clinical information documented above are accurate to the best of my knowledge and are supported by the patient's medical record.

Prescribing Provider: _____

Credentials: _____

NPI: _____

Provider Signature: _____

Date: _____

Provider Phone: _____

Provider Fax: _____

SUPPORTING DOCUMENTATION

Please attach applicable documentation:

☐ **Medication history**

☐ **Lipid laboratory results**

☐ **Documentation of adverse effects/intolerance**

☐ **Previous treatment response**

☐ **Relevant clinical notes**

☐ **Prior authorization correspondence/denial**

☐ **Other: _____**

FAX INFORMATION

Fax Completed Form To: Thrivewell Infusion

Fax Number:646-768-8600

Phone: 212-803-3339