

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



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