

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Sheepshead Bay
2546 East 17th Street
Fl. 1
Brooklyn, NY 11235

Bronx
226 West 238th Street
Bronx, NY 10463

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

Massapequa
97 Grand Avenue
Massapequa, NY 11758

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

NYC

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

Central Park West
115 Central Park West
Suite 15
New York, NY 10023



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



Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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