

Leqvio® (Inclisiran)

Referring Physician Orders Rev. 7/2023

Please fax completed referral form & all required documents to (833) 786-0025



PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ NKDA Weight: _____ lbs kg Height _____ in cm

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

- *ICD 10 Code Required**
- | | |
|---|---|
| <input type="checkbox"/> E78.2 Mixed hyperlipidemia | <input type="checkbox"/> E78.01 Familial Hypercholesterolemia (HeFH) |
| <input type="checkbox"/> E78.41 Elevated Lipoprotein(a) | <input type="checkbox"/> I25.10 Atherosclerotic Heart Disease (ASCVD) |
| <input type="checkbox"/> E78.49 Other hyperlipidemia | |
| <input type="checkbox"/> E78.5 Hyperlipidemia, unspecified | <input type="checkbox"/> Other: _____, ICD10 _____ |
| <input type="checkbox"/> E78.9 Disorder of lipoprotein metabolism | |

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Leqvio®(Inclisiran)	284 mg	INITIAL: <input type="checkbox"/> First dose: Inject SubQ x 1 dose. <input type="checkbox"/> Second dose at 3 months: Inject SubQ x 1 dose. MAINTENANCE: <input type="checkbox"/> Inject SubQ every 6 months x 1 year.

Is patient currently receiving therapy above from another facility?

NO YES

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

- No premeds ordered at this time
 Acetaminophen 650mg PO Other: _____
 Diphenhydramine 25mg PO

LAB ORDERS

- Labs to be drawn by:** Infusion Center Referring Physician
 No labs ordered at this time Other: _____
 LDL-C q _____ Lipid Panel q _____ LFTs q _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/ST/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

For all diagnoses:

- The patient's LDL-C level is elevated despite treatment with maximally tolerated statin therapy.
• Recent LDL-C level: _____ mg/dL; Date lab drawn: _____ (**Attach copy of labwork**)
- The patient is currently on statin therapy.
 Current statin therapy; Drug name: _____ Dosage: _____ Start date or Length of Therapy: _____
 Check box if patient is on Zetia® (ezetimibe) in addition to statin therapy.
- The patient is **not** currently on statin therapy and has documented intolerance or contraindication to statin therapy.
 Patient is statin intolerant. (List failed statin therapies and reasons below.)
 Patient has a contraindication for statin therapy, specify: _____
- The patient has been compliant with lipid lowering drug therapy and lifestyle modifications.

For HeFH only:

- HeFH confirmed by: Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein(LDLRAP1) gene (**Attach copy of test results**)
 WHO/Dutch Lipid Clinic Network Score (DLCNS); Score: _____ (**Attach copy of assessment**)
 Other: _____

For ASCVD only:

History of clinical atherosclerotic cardiovascular disease includes one of more of the following: (**Select all that apply**)

- | | | |
|--|--|--|
| <input type="checkbox"/> Acute coronary syndrome | <input type="checkbox"/> Acute coronary syndrome | <input type="checkbox"/> Acute coronary syndrome |
| <input type="checkbox"/> Coronary artery disease (CAD) | <input type="checkbox"/> Coronary artery disease (CAD) | <input type="checkbox"/> Coronary artery disease (CAD) |
| <input type="checkbox"/> History of myocardial infarction (MI) | <input type="checkbox"/> History of myocardial infarction (MI) | <input type="checkbox"/> History of myocardial infarction (MI) |

LAB RESULTS (required)

- LDL cholesterol blood level

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

Medication: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication: _____	Dates of Treatment: _____	Reason for D/C: _____
Medication: _____	Dates of Treatment: _____	Reason for D/C: _____