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

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

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

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

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

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

REFERRAL
LEQVIO(inclisiran)

Date: _____

Mission Medical

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

LEQVIO Injection*:

*(SELECT **ONE** OF THE FOLLOWING)*

___ **Dosing:** 284 mg subcutaneously Injection

*Frequency: initial dose, again at 3 months, then every 6 months

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

_____ Current Medication List and H&P

FOR MPP USE ONLY

Referral Reviewed and Accepted by: _____ Date approved:_____

Additional information needed/ notes:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone_____ Fax _____