

Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428



REFERRAL LEQVIO(inclisiran)

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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

Refills _____

Continuity of care to leqvio 284mg SubQ every 6 months x 1 year

Refills _____

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
___ Current Medication List and H&P
___ Other

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____