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

Bronx
226 West 238th Street
Bronx, NY 10463

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

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

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

Long Beach
917 Beech Street
Long Beach, NY 11561

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

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

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

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

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

Manhattan
225 E 70th Street
Suite 1E
New York, NY 10021

Manhattan/FIDI
30 Broad Street
Suite 401
New York, NY, 10004

Manhattan/Midtown
120 East 56 Street
Suit 3D
New York, NY 10022

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

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

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

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

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

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

Woodbury
75 Froehlich Farm
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 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 _____________