LEQVIO INJECTION ORDER (INCLISIRAN)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight: _____ lbs / kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ E78.00: Unspecified, Pure Hypercholesterolemia
- ☐ E78.01: Familial Hypercholesterolemia
- ☐ E78.2: Mixed Hyperlipidemia
- ☐ E78.5: Unspecified, Hyperlipidemia
- ☐ Other: _____

LEQVIO THERAPY ORDER

- ☐ Leqvio 284mg SubQ Injection for 3 months, followed by every 6 months x 1 Year.
- ☐ Leqvio 284mg SubQ Injection Eevry 6 months x 1 Year

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994