

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION *SELECT ALL THAT APPLY

- | | |
|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> E78.00 Pure hypercholesterolemia, unspecified | <input type="checkbox"/> E78.49 Other hyperlipidemia, familial combined hyperlipidemia |
| <input type="checkbox"/> E78.010 Homozygous familial hypercholesterolemia (HoFH) | <input type="checkbox"/> E78.5 Hyperlipidemia, unspecified |
| <input type="checkbox"/> E78.011 Heterozygous familial hypercholesterolemia (HeFH) | <input type="checkbox"/> E78.9 Disorder of lipoprotein metabolism, unspecified |
| <input type="checkbox"/> E78.019 Familial hypercholesterolemia, unspecified | <input type="checkbox"/> I25.10 Atherosclerotic heart disease of native coronary artery w/o angina pectoris |
| <input type="checkbox"/> E78.2 Mixed hyperlipidemia | |

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- Insurance Information List of Medications Tried & failed Therapies Most recent History & Physical Lipid Panel within 90 days

MEDICATION ORDER

Induction

LEQVIO® (inclisiran) 284 mg/1.5 ml subcutaneous injection at day 0 and 3 months

Maintenance

LEQVIO® (inclisiran) 284mg/1.5ml subcutaneous injection every 6 months

Previous LEQVIO® dose given on:

DATE: _____

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN