Leqvio® (Inclisiran)

Referring Provider Order Form – For Use with Participating Infusion Centers Rev. 7/2023

Please send completed referral form & all required documents to **referrals@healix.net** or fax to **281-295-4086**

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ____________ Phone: ____________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height________ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ E78.2 Mixed hyperlipidemia
☐ E78.41 Elevated Lipoprotein(a)
☐ E78.49 Other hyperlipidemia
☐ E78.5 Hyperlipidemia, unspecified
☐ E78.9 Disorder of lipoprotein metabolism
☐ E78.01 Familial Hypercholesterolemia (HeFH)
☐ I25.10 Atherosclerotic Heart Disease (ASCVD)
☐ Other: ______________________, ICD10 __________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Leqvio®(Inclisiran)	284 mg	**INITIAL:** ☐ First dose: Inject SubQ x 1 dose. ☐ Second dose at 3 months: Inject SubQ x 1 dose. **MAINTENANCE:** ☐ Inject SubQ every 6 months x 1 year.

Is patient currently receiving therapy above from another facility?
☐ NO ☐ YES

If yes, Facility Name: ______________________

Date of last treatment: ____________ Date of next treatment: ____________

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Other: ______________________
☐ Diphenhydramine 25mg PO

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
☐ No labs ordered at this time ☐ Other: ______________________
☐ LDL-C q ________ ☐ Lipid Panel q ________ ☐ LFTs q ________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ____________

Physician Name: ____________ Provider NPI: ____________ Specialty: ____________

Address: ______________________ City/ST/Zip: ____________

Contact Person: ____________ Phone #: ____________ Fax #: ____________

Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

For all diagnoses:

☐ Yes ☐ No Is the patient's LDL-C level elevated despite treatment with maximally tolerated statin therapy?
- Recent LDL-C level: _______ mg/dL; Date lab drawn: ____________ ***(Attach copy of labwork)***

☐ Yes ☐ No Is the patient currently on statin therapy?

Current statin therapy; Drug name: ____________ Dosage: ________ Start date or Length of Therapy: ____________

☐ Check box if patient is on Zetia® (ezetimibe) in addition to statin therapy.

If No, please specify: ☐ Patient is statin intolerant (list failed statin therapies and reasons below)
☐ Patient has a contraindication for statin therapy, specify: ______________________
☐ Other: ______________________

☐ Yes ☐ No Has the patient been compliant with lipid lowering drug therapy and lifestyle modifications?

For ASCVD only:

History of clinical atherosclerotic cardiovascular disease includes one of more of the following: ***(Select all that apply)***

☐ Acute coronary syndrome
☐ Coronary artery disease (CAD)
☐ History of myocardial infarction (MI)
☐ Stable or unstable angina
☐ Coronary or other arterial revascularization
☐ Stroke
☐ Transient ischemic attack (TIA)
☐ Peripheral arterial disease (PAD)
☐ Other: ______________________

For HeFH only:

HeFH confirmed by: ☐ Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein(LDLRAP1) gene ***(Attach copy of test results)***
☐ WHO/Dutch Lipid Clinic Network Score (DLCNS); Score: ______ ***(Attach copy of assessment)***
☐ Other: ______________________

LAB RESULTS (required)

☐ LDL cholesterol blood level

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

Medication: ____________ Dates of Treatment: ____________ Reason for D/C: ____________

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