

New Referral

Dose or Frequency Change

Order Renewal

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Allergies: _____ Weight:(lbs) _____ Height: _____
Phone: _____ Email: _____

ICD CODE/ICD DESCRIPTION

Primary Diagnosis: _____ Secondary Diagnosis: _____
Other: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider NPI: _____
Phone: _____ Fax: _____
Practice Site Name: _____
Practice Address: _____

REQUIRED DOCUMENTATION

- This order is signed by provider
- Patient's demographics AND insurance information
- Clinical/progress notes supporting primary diagnosis
- Labs and tests supporting primary diagnosis

Tried and failed therapies: _____

MEDICATION ORDERS

Leqvio (Inclisiran)

- Loading dose: Inject 284 mg subcutaneously week 0, then 3 months, then every 6 months thereafter
- Maintenance dose: Inject 284 mg subcutaneously every 6 months

Refills: x6 months x1 year
***Order valid x1 year unless indicated**

Special Instructions

Provider Name

Provider Signature

____/____/____
Date