FAX: 725.228.5220 eMediate INFUSION

LEQVIO

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

PATIENT INFORMATION

*Patient Insurance & ID (front and back) are needed

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Leqvio:
(inclisiran)

☐ 284mg SubQ at Day 0, Months 3, and every 6 months (initial start) x 1 year
☐ 284mg subcutaneously every 6 months x 1 year
☐ Others: _____

_____

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg ☐ 1000mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx: Diagnosis:

☐ Pure hypercholesterolemia, unspecified (ICD-10: E78.00)
☐ Mixed hyperlipidemia (ICD-10: E78.2)
☐ Familial hypercholesterolemia (ICD-10: E78.01)
☐ Hyperlipidemia, unspecified (ICD-10: E78.5)
☐ ASCHD w/o angina pectoris (ICD-10: I25.10)

Other:_____ ICD-10: _____

PRESCRIBER SIGNATURE: x

Date (Valid for 1 year):

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results