☐ *Need a referral status update, Please provide your email:* _____

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

CARDIOLOGY

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx: **Patient Name:** **Patient Weight:** kg **DOB:**

Diagnosis:

ICD-10 Code:

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: _____

_____

Diagnosis:

Iron Deficiency in heart failure

ICD-10 Code:

Injectafer (ferric carboxymaltose)

☐ **1st dose:** 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins

☐ **2nd dose:** 7 days after the 1st dose, 750mg IV infusion in no more than 250ml of 0.9% NaCl over at least 15 mins or slow IV push over 7.5 mins

☐ **Others:** _____

Venofer (iron sucrose)

☐ 200mg in 100ml NaCl over 15 mins x 5 doses via IV infusion over a 14-day period. Total = 1000mg.

☐ 200mg IV push over 2 to 5 mins x 5 doses over a 14-day period. Total = 1000mg.

☐ **Others:** _____

☐ May substitute with any formulary-approved intravenous iron preparation per insurance coverage

Pre-Medication:

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

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

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

ANA Kit Protocol:
☐ OK to use

Physician Signature **NPI #:** **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.

PHYSICIAN INFORMATION

Physician Name: **Clinic:**

Phone: **Fax:** **Email:** **Other:**

Office Mailing Address:

Please include the following

☐ Patient demographics ☐ Insurance attached ☐ Diagnosis(supporting) ☐ History & Physical
☐ Lab Results ☐ Clinical progress notes ☐ Medication list ☐ Other Test Results
☐ Cholesterol with LDL-C (Leqvio)

***If TB or Hep B results are positive - please provide documentation of treatment or medical clearance & a negative CXR (TB+)**