Leqvio Injection Order

Fax 888 511-7654 Phone 888 864 7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ E78.00 Pure Hypercholesterolemia, unspecified
- ◯ E78.01 Familial hypercholesterolemia
- ◯ E78.2 Mixed Hyperlipidemia
- ◯ E78.49 Other hyperlipdemia, familial combined hyperlipidemia
- ◯ E78.5 Hyperlipidemia, unspecified
- ◯ I25.10 Atherosclerotic cardiovascular disease **(Medicare requires I25.10 to be accompanied with an E code.)**
- ◯ Other _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

LEQVIO ORDER

Leqvio Dose:

◯ New Patient — 284 mg perfilled syringe, 0, 3 months then every 6 months

◯ Existing Patient — 284 mg prefilled syringe, Every 6 months

Date of last Leqvio Injection: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____