Inclisiran (Leqvio)

Provider Order Form rev. 03/30/2022

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

☐ ICD-10-CM diagnosis code Description Disorders of lipoprotein metabolism and other lipidemias

☐ E78.00 Pure hypercholesterolemia, unspecified

☐ E78.01 Familial hypercholesterolemia

☐ E78.2 Mixed hyperlipidemia

☐ E78.4 Other hyperlipidemia

☐ E78.49 Other hyperlipidemia, familial combined hyperlipidemia

☐ E78.5 Hyperlipidemia, unspecified

☐ E78.9 Disorder of lipoprotein metabolism, unspecified

☐ Secondary diagnosis code: _____

MEDICATION ORDER

Inclisiran (Leqvio)
Dose: inclisiran sodium 284mg (pre-filled syringe)
Route: subcutaneous injection
Frequency: initial dose, again at 3 months, then every 6 months.

Refills: ☐ Zero / ☐ for 12 months /

☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months