MIC | METRO INFUSION CENTER

INFUSION ORDERS- Leqvio® (inclisiran)

PATIENT INFORMATION		
Name:	DOB:	Weight:_____
Allergies:	Date of Referral:	

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*

DIAGNOSIS AND ICD 10 CODE	
☐ heterozygous familial hypercholesterolemia (HeFH)	ICD 10 Code: E78.01
☐Clinical atherosclerotic cardiovascular disease (ASCVD)	ICD 10 Code: 125.10

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info	☐ Clinical/Progress notes supporting primary dx ☐ Verification/documentation that LDL-C has not reached the target of <70mg/dl
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS

Biologic Injection/Infusion Order

Medication	Dosing/Diluent	Route	Rate of infusion	Dates of administration
☐ Leqvio	284mg/1.5ml prefilled syringe	SQ	N/A	Dose 1:_____ 3 months post 1st:_____ Every 6 months starting:_____
☐ Leqvio	284mg/1.5ml prefilled syringe	SQ	N/A	Every 6 months First dose:_____

Refills: ☐ X 6 months ☐ X 1 year ☐ _____ dose

OTHER ORDERS

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Contact Name:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: [877] 448-3627
Send Completed Form and all documentation to:
Confidential email: Intake@Metroinfusioncenter.com or [866] 507-1164