Inclisiran (Leqvio)

MIC | METRO INFUSION CENTER

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

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:		Office Email:	
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE	
☐ Heterozygous Familial Hypercholesterolemia	ICD-10 Code: E78.01
☐ Mixed hyperlipidemia	ICD-10 Code: E78.2
☐ Hyperlipidemia, unspecified	ICD-10 Code: E78.5
☐ Clinical atherosclerotic cardiovascular disease (ASCVD)	ICD-10 Code: I25.10
☐ Other: _____	ICD-10 Code: _____

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)	

BIOLOGIC ORDERS	
Initial Dosing	☐ Leqvio 284mg subcutaneously at months 0,3 and then every six months thereafter
Maintenance Dosing	☐ Leqvio 284mg subcutaneous every 6 months
	Please only mark one of the above boxes
Refills*:	☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ *(if not indicated order will expire one year from date signed)*

SPECIAL INSTRUCTIONS

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

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Revised 1/27/23