

Leqvio (inclisiran)

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: E78.011
☐ Mixed hyperlipidemia ICD-10 Code: E78.2
☐ Hyperlipidemia, unspecified ICD-10 Code: E78.5
☐ Clinical atherosclerotic cardiovascular disease (ASCVD) ICD-10 Code: I25.10

REQUIRED DOCUMENTATION/Testing

☐ This signed order form by the provider ☐ Clinical/Progress notes supporting primary dx
☐ Patient demographics AND insurance info ☐ 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 03/09/26