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Leqvio (Inclisiran)

Provider Order Form rev. 5/20/2022

PATIENT INFORMATION

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
	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:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

- E78.00 Pure hypercholesterolemia, unspecified
- E78.01 Familial hypercholesterolemia
- E78.2 Mixed hyperlipidemia, familial combined hyperlipidemia
- E78.49 Other hyperlipidemia, familial combined hyperlipidemia
- E78.5 Hyperlipidemia, unspecified
- E78.9 Disorder of lipoprotein metabolism, unspecified
- Other: _____

MEDICATION ORDER

Leqvio (Inclisiran)
Dose: 284mg SC
Frequency: Give at month 0, 3 then every 6 months thereafter
Every 6 months
Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order