

LEQVIO[®] Referral/Order Form

Once all of the requirements below have been completed and checked off, please call to schedule appointment at (740) 356-7490 and if non-SOMC provider fax all documents to (740) 356-7488. If you any questions or special needs, please discuss them at the time of scheduling. Thank you!

Name: _____ Date of Birth: _____

Phone Number: Home _____ Cell _____ Weight: _____

Allergies: _____

Clinical Information

Primary ICD-10-CM Diagnosis Code

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

Secondary ICD-10-CM Diagnosis Code

Secondary Code: _____

Patient status and treatment history

Include patient chart notes to support documentation payers may require, such as:

- Clinical documentation for specified ICD-10-CM diagnosis codes
- Recent comprehensive lipid panel/LDL-C values (in the last 90 days)
- Statin history and/or additional lipid-lowering treatment
- Statin intolerance (if applicable)
- Counseling on the importance of lifestyle modifications including diet and exercise

LEQVIO ORDER (select all that apply) - Order valid for 1 year from provider signature date

Initial dose → LEQVIO (inclisiran) 284 mg/1.5 mL subcutaneous initially, then LEQVIO (inclisiran) 284 mg/1.5 mL subcutaneous in 3 months

Maintenance dose → LEQVIO (inclisiran) 284 mg/1.5 mL subcutaneous every 6 months

Other: → LEQVIO (inclisiran) 284 mg/1.5 mL subcutaneous _____

Previous LEQVIO dose given on: _____ / _____ / _____

Provider Signature:

DATE:	TIME:	SIGNATURE:
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Printed Provider Name: _____

Phone number of referring provider: Phone # _____

Fax number of referring provider: Fax # _____

Reviewed and Approved Dr. Saab/J Janney/Order Set Team 11/18/2022

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