

**LEQVIO® (inclisiran)**  
Referral/Order Form

**GAMMA THERAPEUTIC**  
**CENTER**  
Center for Neurological Disorders

Phone: (414) 460-3195  
Fax: (414) 763-0063  
www.gtinfusions.com

Patient Information		
Patient Name:		Patient DOB:
Referral Status		
<input type="checkbox"/> New Order	<input type="checkbox"/> Continuation	<input type="checkbox"/> Order Change <input type="checkbox"/> D/C Infusions <input type="checkbox"/> Restart
Diagnosis and ICD 10 Code		
<input type="checkbox"/> Heterozygous Familial Hypercholesterolemia (HeFH)	ICD 10 Code: E78.01	
<input type="checkbox"/> Other Diagnosis:	ICD 10 Code:	
<input type="checkbox"/> Other Diagnosis:	ICD 10 Code:	
Has patient been diagnosed with ASCVD and/or HeFH, is currently receiving maximally tolerated statin therapy (or has been determined clinically intolerant), and has not reached LDL-C target (<70 mg/dL)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Supporting Documentation		
<input type="checkbox"/> Patient demographics	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis	
<input type="checkbox"/> Copy of patient insurance card(s) – front & back	<input type="checkbox"/> Labs and tests supporting diagnosis code	
<input type="checkbox"/> Tried and Failed therapies	<input type="checkbox"/> Current Medication List	
Medication Orders		
<input type="checkbox"/> Initial Dosing: Leqvio® (inclisiran) 284mg subQ injection at 0 and 3 months		
<input type="checkbox"/> Maintenance Dosing: Leqvio® (inclisiran) 284mg subQ injection every 6 months		
Notes (Additional Info)		
<b>Premedication, adverse and anaphylactic reactions and post injection will be treated per Gamma Therapeutic Center protocol.</b>		
Prescriber Information		
Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: <small>(Order is valid for one year)</small>
My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.		
<b>Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</b>		

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