

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

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>		

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.