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

☐ New Order ☐ Continuation ☐ Order Change ☐ D/C Infusions ☐ Restart

Diagnosis and ICD 10 Code

☐ Heterozygous Familial Hypercholesterolemia (HeFH)	ICD 10 Code: E78.01
☐ Other Diagnosis:	ICD 10 Code:
☐ 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)? ☐ **Yes** ☐ **No**

Supporting Documentation

☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests supporting diagnosis code
☐ Tried and Failed therapies	☐ Current Medication List

Medication Orders

☐ Initial Dosing: Leqvio® (inclisiran) 284mg subQ injection at 0 and 3 months

☐ Maintenance Dosing: Leqvio® (inclisiran) 284mg subQ injection every 6 months

Notes (Additional Info)

Premedication, adverse and anaphylactic reactions and post injection will be treated per Gamma Therapeutic Center protocol.

Prescriber Information

Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order is valid for one year)

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.

Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.