EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Leqvio® Order Form
(inclisiran)

FAX TO: 817-472-7213

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

INSURANCE INFORMATION: *Please attach copy of insurance card (front and back)*

Diagnosis

ICD 10 Code Required

☐ E78.2 Mixed hyperlipidemia
☐ E78.41 Elevated Lipoprotein(a)
☐ E78.49 Other hyperlipidemia
☐ E78.5 Hyperlipidemia, unspecified
☐ E78.9 Disorder of lipoprotein metabolism
☐ E78.01 Familial Hypercholesterolemia (HeFH)
☐ I25.10 Atherosclerotic Heart Disease (ASCVD)
Other: _____ ICD 10 _____

Infusion Orders

DIRECTIONS/DURATION

DOSE: 284 mg

INITIAL: ☐ First dose: Inject SubQ x 1 dose
☐ Second dose at 3 months: Inject SubQ x 1 dose

MAINTENANCE: ☐ Inject SubQ every 6 months x 1 year

Is patient currently receiving therapy above from another facility?
☐ YES ☐ NO

If yes, Facility Name: _____
Date of last treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Other: _____
☐ Diphenhydramine 25mg PO

LAB ORDERS

Labs to be drawn by: ☐ Medix Infusion ☐ Referring Physician
☐ No labs ordered at this time ☐ Other: _____
☐ LDL-C q _____ ☐ Lipid Panel q _____ ☐ LFTs q _____

Required Clinical Documentation

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

Clinical information, select all that apply:

For all diagnoses

☐ The patient's LDL-C level is elevated despite treatment with maximally tolerated statin therapy
- Recent LDL-C level: _____ mg/dl; Date lab drawn: _____ *(Attach copy of paperwork)*

☐ The patient is currently on statin therapy
☐ Current statin therapy; Drug name: _____ Dosage: _____ Start Date or Length of Therapy: _____
☐ Check box if patient is on Zetia® (ezetimibe) in addition to statin therapy

☐ The patient is ***not*** currently on statin therapy and has documented intolerance or contraindication to statin therapy
☐ Patient is statin intolerant (List failed statin therapies and reasons below)
☐ Patient has a contraindication for statin therapy, specify: _____

☐ The patient has been compliant with Lipid lowering drug therapy and lifestyle modifications

For HeFH only

HeFH confirmed by: ☐ Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein(LDLRAP1) gene ***(Attach copy of assessment)***
☐ WHO/Dutch Lipid Clinic Network Score (DLCNS); Score: _____ ***(Attach copy of assessment)***
☐ Other: _____

For ASCVD only:

History of clinical atherosclerotic cardiovascular disease includes one or more of the following: ***(Select all that apply)***

☐ Acute coronary syndrome
☐ Coronary artery disease (CAD)
☐ History of myocardial infarction
☐ Stable or unstable angina
☐ Coronary or other arterial revascularization
☐ Stroke
☐ Transient ischemic attack (TIA)
☐ Peripheral arterial disease (PAD
☐ Other: _____

LAB RESULTS (required)

☐ LDL cholesterol blood level

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____
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Patient has received dietary counseling related to hyperlipidemia and CV disease

Referring Physician Information

Prescriber Name: _____ Signature: _____
Date: _____ NPI #: _____ Specialty: _____
Supervising Physician: _____ (If Applicable)
Address: _____ City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____ Fax: _____ Email: _____