Leqvio (Inclisiran)

Provider Order Form rev. 5/20/2022

AleraCare
A Healthcare Solutions Company
www.aleracare.com
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PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ I25.10 Atherosclerotic Cardiovascular disease (ASCVD)

☐ E78.01 Familial hypercholesterolemia

☐ E78.2 Mixed hyperlipidemia, familial combined hyperlipidemia

☐ E78.49 Other hyperlipidemia, familial combined hyperlipidemia

☐ Other: _____

MEDICATION ORDER

Leqvio (Inclisiran)

Dose:

☐ 284mg SC

Frequency:

☐ Give at month 0, 3 then every 6 months thereafter

☐ Every 6 months

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**