

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance cardfront and back (required)

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City/ST/Zip: _____
Allergies: _____ [] NKDA Weight: _____ [] lbs [] kg Height: _____ [] in [] cm

DIAGNOSIS*

ICD-10 CODE (required)

Please complete 2nd and 3rd digits to complete ICD-10 for billing

- [] E78.00 Pure Hypercholesterolemia
[] E78.010 Homoygous Familial Hypercholesterolemia (H0FH)
[] E78.011 Heterozygous Familial Hypercholesterolemia (HeFH)
[] E78.2 Mixed Hyperlipidemia
[] E78.49 Other Hyperlipidemia, familial combined hyperlipidemia
[] E78.5 Hyperlipidemia, unspecified
[] I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
[] I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
[] I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
[] I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
[] I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
[] I25.700 Atherosclerotic or coronary artery bypass graft(s), unspecified, with unstable angina pectoris
[] I25.701 Atherosclerotic or coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm
[] Other: _____, ICD 10 _____

INFUSION ORDERS

MEDICATION DOSE DIRECTIONS/DURATION
Leqvio® (inclisiran) [] Initial & Maintenance: 284mg [] Initial & Maintenance: Administer 284mg subcutaneously at day 0, month 3, then every 6 months
[] Maintenance: 284mg [] Maintenance: Administer 284mg subcutaneously every 6 months
[] Patient has tried and failed a Statin and/or Repatha or Praluent to meet insurance step therapy requirements? If so, please list: _____
[] Refills for one year from date of signature unless indicated below _____ Refills

Is patient currently receiving therapy above from another facility? [] NO [] YES
If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: [] Infusion Center [] Referring Physician
[] No labs ordered at this time
[] CBC q _____ [] CMP q _____ [] CRP q _____ [] ESR q _____ [] LFTs q _____ [] Other: _____
PRE-MEDICATION ORDERS:
[] No premeds ordered at this time [] Diphenhydramine 25mg PO [] Other: _____
[] Acetaminophen 650mg PO [] Methylprednisolone 40mg IVP -OR- [] Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
Physician Name: _____ Provider NPI: _____ Specialty: _____
Address: _____ City/ST/Zip: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

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

TEST RESULTS (required)

- TB screening for Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
[] Annual TB screening to be done by: [] Infusion Center [] Referring Physician

Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizimab biosimilars and Rituxan (submit results to start therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For SLE: [] Autoantibody test (ANA, anti-dsDNA)

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____