LEQVIO (INCLISIRAN) ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐New to Therapy ☐Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

Diagnosis:

- ☐ Pure hypercholesterolemia, unspecified **ICD-10 code: E78.00**
- ☐ Familial hypercholesterolemia **ICD-10 code: E78.01**
- ☐ Mixed hyperlipidemia **ICD-10 code: E78.2**
- ☐ Hyperlipidemia, unspecified **ICD-10 code: E78.5**
- ☐ ASCH without angina pectoris **ICD-10 code: I25.10**
- ☐ Other: _____ **ICD-10 code:** _____

THERAPY ORDER

LEQVIO

- ☐ 284 mg subcutaneously initially, at 3 months, and then every 6 months (initial start) x 1 year

- ☐ 284 mg subcutaneously every 6 months x 1 year

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____

Provider NPI: _____ Phone: _____ Fax: _____

Contact Person: _____ Date: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR LEQVIO (INCLISIRAN) THERAPY

P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Heterozygous familial hypercholesterolemia (HeFH) – Does the patient have a untreated LDL ≥ 190mg/dL Yes No

    Please mark any of the following criteria the HeFH patient meets:
    - ☐ Presence of tendon xanthoma(s) in the patient or 1st/2nd degree relative
    - ☐ Family history of MI at <60 years old in 1st degree relative of <50 years old in 2nd degree relative
    - ☐ Family history of total cholesterol > than 290mg/dL in a 1st/2nd degree relative
    - ☐ Arcus cornealis before age 45
  - ☐ ASCVD – Does the patient's LDL remain ≥100 mg/dL despite treatment with a high intensity statin? ☐ Yes ☐ No
  - ☐ Has the patient tried and failed PCSK9 inhibitor after 12 weeks of use? ☐ Yes ☐ No
  - ☐ Has the patient tried and failed a high intensity statin for ≥ 8 continuous weeks? ☐ Yes ☐ No
    - ☐ If yes, SAM-C score: _____ **Please attach SAM-C score form.**
  - ☐ The patient has any of the following conditions: ☐ Acute coronary syndrome ☐ History of myocardial infarction ☐ Stroke ☐ Coronary or other arterial revascularization ☐ Transient ischemic attack ☐ Peripheral arterial disease presumed to be of atherosclerotic origin
- ☐ Include labs and/or test results to support diagnosis
  - ☐ LDL-C **(required)**
  - ☐ Mutation in LDL, apoB, or PCSK9 gene (if applicable)
- ☐ Other medical necessity: _____

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance