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: ___________________________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

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

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ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder? ☐ Yes ☐ No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION