ivira infusions

Leqvio Referral Form

Please fax completed referral form to ivira:
(302) 486-3400
Please contact office for questions:
(302) 356-0506

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH: GENDER: ☐ F ☐ M	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ E78.01 - Familial Hypercholesterolemia ☐ Z83.42 - Family History of Familial Hypercholesterolemia
☐ I25.10 - Atherosclerotic Heart Disease of native coronary artery without angina pectoris ☐ OTHER: _____

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECECNT LABS ☐ 4. H & P
☐ DOCUMENTATION OF ALL PREVIOUSLY ATTEMPTED THERAPIES, INTOLERANCES, OR CONTRAINDICATIONS

MEDICATION SELECTION:

LEQVIO® (inclisiran) injection 284 mg/1.5 mL

☐ INDUCTION: 284mg subcutaneous injection at day 0, month 3, and every 6 months thereafter REFILLS: 1yr
☐ MAINTENANCE: 284mg subcutaneous injection every 6 months REFILLS: 1yr

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: