

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Are LDL levels elevated? Y N • ASCVD Risk Score: _____
- Current Lipid Lowering Regimen: _____

PRIMARY AND SECONDARY DIAGNOSIS
Primary Diagnosis

- E78.00 Pure hypercholesterolemia, unspecified
- E78.011 Heterozygous familial hypercholesterolemia [HeFH]
- E78.019 Familial hypercholesterolemia, unspecified
- E78.2 Mixed hyperlipidemia
- E78.4 Other hyperlipidemia
- E78.5 Hyperlipidemia, unspecified
- Other: _____

Secondary Diagnosis

- I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
- Z95.820 Peripheral vascular angioplasty status with implants and grafts
- I10 Essential Hypertension
- E11._____ Diabetes Mellitus
- N18._____ Chronic Kidney Disease
- Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: There are no recommended standard pre-meds for Leqvio
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Leqvio 284mg subQ at Day 0, Month 3, and every 6 months thereafter
- Leqvio 284mg subQ every _____ months
- Other: _____

First Dose: Y N Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date