MRN:_____
DOB: _____

Standard Plan of Treatment for Leqvio® (Inclisiran)

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.*

1. **Patient Name**: _____Height (in.):_____ Weight (lbs):_____
2. **Allergies**: _____
3. **Diagnosis:**

☐ E78.01: Familial Hypercholesterolemia ☐ Z83.42: Family History of Familial Hypercholesterolemia

☐ I25.10 Atherosclerotic Heart Disease of native coronary artery without angina pectoris

☐ Other ICD-10_____ Diagnosis description: _____

4. Dose:

☐ **Induction: Administer 284mg/1.5ml at day 0, month 3 and then every 6 months.**

☐ **Maintenance: Administer 284mg/1.5ml every 6 months**

Special Orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____ **Date**: _____
(Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

6. ***Fax updated supporting clinical MD notes with each order renewal or change in orders***

MRN:_____
DOB: _____

Guidelines for Prescribing

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-6)*

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ Include patient's current Statin therapy or documentation of intolerance.

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- Leqvio® is Indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD), who require additional lowering of low-density lipoprotein cholesterol (LDL-C).

☐ Other as requested: _____
_____
_____
_____

Pre-Screening:

☐ Baseline Lipid Panel

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.