INTRAMED Plus
infusion services

LEQVIO®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis:
_____Atherosclerotic Heart Disease ICD-10 Code: I25.10
_____Familial Hypercholesterolemia ICD-10 Code: E78.01
_____Family History of Familial Hypercholesterolemia ICD-10 Code: Z83.42
_____Other: _____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results including a baseline lipid panel
- Medication List
  - Include all cholesterol therapies trialed as well as documentation of efficacy, treatment failures and or intolerances to any agents

Patient
Weight: _____ lbs.
Height:_____ in.

LEQVIO® (inclisiran) J Code: J1306

4. Drug Order:

❑ **New Start** 3 (Three) Doses Authorized
Administer 284 mg subcutaneously initially, again at 3 months and then every 6 months

❑ **Maintenance Regimen** _____# Refills (Recommend 1 Refills)
Administer 284 mg subcutaneously every 6 months

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 800.767.6337