

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

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|-----------------------------------|
| Patient Weight: _____ lbs. |
| Patient Height: _____ in. |

Infusion Center: Lab Orders: (Check order for Infusion Center to manage):

Obtain fasting lipid panel every _____ months

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 #: _____

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| FAX ALL INFORMATION CENTRAL FAX 803.999.1754 | LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760 |
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