Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Heterozygous Familial Hypercholesterolemia (HeFH) ICD 10 Code: E78.01

☐ Clinical Atherosclerotic Cardiovascular Disease (ASCVD) ICD 10 Code: 125.10

☐ Hyperlipidemia ICD 10 Code: E78.5

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Lipid Panel

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis

☐ Verification/documentation that LDL-C has not reached the target of <70mg/dl

Current and previous lipid-lowering therapy -- select all that apply

☐ Atorvastatin (LIPITOR®) ---------- ☐10 ☐20 ☐40 ☐80 ---- Dates/length of use: _____

☐ Pravastatin (PRAVACHOL®) ------ ☐10 ☐20 ☐40 ☐80 ---- Dates/length of use: _____

☐ Simvastatin (ZOCOR®) ---------- ☐10 ☐20 ☐40 ☐80 ---- Dates/length of use: _____

☐ Rosuvastatin (CRESTOR®) ------ ☐10 ☐20 ☐40 ☐80 ---- Dates/length of use: _____

☐ Ezetimibe (ZETIA®) ---------- ☐10 ☐20 ☐40 ☐80 ---- Dates/length of use: _____

☐ Other: _____ ☐10 ☐20 ☐40 ☐80 ---- Dates/length of use: _____

☐ Patient had inadequate response to maximally tolerated lipid-lowering therapy

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Medication	Dosing/Diluent	Route	Administration
☐ Leqvio	284mg/1.5ml prefilled syringe	SubQ	Initial Dose 3 months Every 6 months
Maintenance Dosing			
☐ Leqvio	284mg/1.5ml prefilled syringe	SubQ	Every 6 months

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - LEQVIO® (inclisiran)

Clinics Scan to: Physician Orders