# LEQVIO (INCLISIRAN) REFERRAL FORM

## PATIENT INFORMATION

Patient Name: ______________________________ DOB: __________

Address: ______________________________

City: ______________ State: ______________ Zip: __________

Home Phone: ______________ Work Phone: ______________

Allergies: ______________________________

Is patient pregnant? ☐ Yes ☐ No Patient's Height: __________ Patient's Weight (kg): __________

☐ 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).

## DIAGNOSIS INFORMATION:

Heterozygous Familial Hypercholesterolemia (HeFH) or clinical Atherosclerotic cardiovascular disease (ASCVD)

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

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

☐ Other IDC-10 __________ Diagnosis description: ______________________________

## LEQVIO (INCLISIRAN)

☐ 284 mg subcutaneously on month 0, 3, then every 6 months x 1 year.

☐ **Continuation of Care.** Last Dose: ______________ Next Dose Due: ______________

## IN CASE OF REACTION

Follow Oso Protocol for anaphylaxis and infusion reactions

## NURSING

Oso to coordinate nursing services in Ambulatory Infusion Suite.

## PHYSICIAN INFORMATION

MD Name: ______________________ Office Contact: ______________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

MD Signature: ______________________________ Date: ______________