# LEQVIO (INCLISIRAN)
## Injection Orders

**PHONE** 515.225.2930 | **FAX** 515.559.2495

### Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

**Patient Name:** _____ **DOB:** _____ **Phone:** _____

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

### Medical Information

**Diagnosis:**

☐ Pure hypercholesterolemia, unspecified (ICD-10 Code: E78.00)
☐ Familial hypercholesterolemia (ICD-10 Code: E78.01)
☐ Mixed hyperlipidemia (ICD-10 Code: E78.2)
☐ Other hyperlipidemia (ICD-10 Code: E78.4)
☐ Hyperlipidemia, unspecified (ICD-10 Code: E78.5)
☐ Disorder of lipoprotein metabolism (ICD-10 Code: E78.9)
☐ Other hyperlipidemia, familial combined hyperlipidemia (ICD-10 Code: E78.49)
☐ Other: _____ ICD-10 Code: _____

**Patient Weight:** _____ lbs. (required) **Allergies:** _____

### Therapy Order

**Leqvio –** *choose 1:*

☐ 284 mg subcutaneously initially, at 3 months, then every 6 months (initial start) x1 year
☐ 284 mg subcutaneously every 6 months x1 year

**Lab Orders:** _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Provider

Other orders: _____

### Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Provider Name:** _____ **Signature:** _____ **Date:** _____

**Provider NPI:** _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

### Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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# COMPREHENSIVE SUPPORT FOR LEQVIO (INCLISIRAN) THERAPY

## Patient Information

**Patient Name:** _____ **DOB:** _____

## Required Documentation for Referral Processing & Insurance Approval

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy
  - ☐ Heterozygous familial hypercholesterolemia (HeFH) – Does the patient have a untreated LDL ≥190 mg/dL (≥155 mg/dL if <16 years of age)? ☐ Yes ☐ No
  - ☐ ASCVD – Does the patient's LDL remain ≥70 mg/dL despite treatment with a high-intensity statin? ☐ Yes ☐ No
  - ☐ Has the patient tried and failed PCSK9 inhibitor after 12 weeks of use? ☐ Yes ☐ No
  - ☐ Has the patient tried and failed a high intensity statin for ≥8 continuous weeks? ☐ Yes ☐ No
  - ☐ Indicate any conditions the patient has:
    - ☐ Acute coronary syndrome ☐ History of myocardial infarction ☐ Stroke
    - ☐ Coronary or other arterial revascularization ☐ Transient ischemic attack
    - ☐ Peripheral arterial disease presumed to be of atherosclerotic origin
- ☐ Include labs and/or test results to support diagnosis
  - ☐ LDL-C **(required)**
- ☐ Other medical necessity: _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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