REVITALIZE
INFUSION CENTER

Leqvio®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

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
☐ Hypercholesterolemia ICD-10 Code: E78.___
☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed cholesterol therapies
- Required Information:
  - Lipid panel within the last 90 days

Height: _____

Weight: _____

Leqvio (inclisiran) Orders:

☐ New Start: Administer 284 mg subcutaneously initially, again at 3 months and then every 6 months for 12 months (3 doses)

☐ Maintenance Therapy: Administer 284 mg subcutaneously every 6 months for 12 months (2 doses)

Lab Orders:

☐ Fasting lipid panel every _____ months
☐ Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

Please fax the completed order form an all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus