

Infusion Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

- ☐ Atherosclerotic Heart Disease
- ☐ Familial Hypercholesterolemia
- ☐ Family History of Familial Hypercholesterolemia
- ☐ Hypercholesterolemia
- ☐ Other _____

ICD-10 Code: I25.10

ICD-10 Code: E78.01

ICD-10 Code: Z83.42

ICD-10 Code: E78.____

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 and 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

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