

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____
Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Diagnosis:
 Familial hypercholesterolemia (ICD-10:E78.01)
 ASCHD w/o angina pectoris (ICD-10: I25.10)
 Other: _____ ICD-10: _____

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

THERAPY ORDER

Leqvio - choose one:

- 284mg subcutaneously initially, at 3 months, and then every 6 months (initial start) x 1 year
- 284mg subcutaneously every 6 months x 1 year

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

Required labs to be drawn by: Paragon Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. 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 Paragon selecting site of care (if checked, please list site of care): _____

PREFERRED LOCATION

City: _____ State: _____

View our locations here:



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 \geq 190mg/dL (\geq 155mg/dL if $<$ 16 years of age)? Yes No
- Please mark any of the following criteria the HeFH patient meets:
- Presence of tendon xanthoma(s) in the patient or 1st/2nd degree relative
 - Family history of MI at $<$ 60 years old in 1st degree relative or $<$ 50 years old in 2nd degree relative
 - Family history of total cholesterol $>$ than 290mg/dL in a 1st/2nd degree relative
 - Arcus cornealis before age 45
- ASCVD - Does the patient's LDL remain \geq 70mg/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 \geq 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**)
 - Mutation in LDL, apoB, or PCSK9 gene (if applicable)
 - Other medical necessity: _____

Paragon Healthcare 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.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance

PARAGONHEALTHCARE.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.