A Carelon Company

LEQVIO (INCLISIRAN) THERAPY INJECTION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:
Office Contact:				Email:
Address:		City:	State:	ZIP:
NPI #:	DEA#:			Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Leqvio (inclisiran)	☐ Initial start: 284mg subcutaneously initially, at 3 months, and then every 6 months ☐ 284mg subcutaneously every 6 months	☐ x 1 year ☐ __________

Other orders: ____

Lab Orders: ____ Lab frequency: _______________________

Required labs to be drawn by ☐ Paragon Healthcare ☐ Referring Provider

As required by your state, Prescriber to check “Dispense as written” or handwrite “Brand Medically Necessary” and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

PARAGON HEALTHCARE
A Carelon Company

COMPREHENSIVE SUPPORT FOR LEQVIO (INCLISIRAN) THERAPY

PATIENT INFORMATION

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 ≥ 190mg/dL (≥ 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 ≥ 100mg/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)**
  - ☐ Mutation in LDL, apoB, or PCSK9 gene (if applicable)
- ☐ Other medical necessity: ______________________________