



Checklist for LEQVIO Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ NPI: _____

Referring Office Contact/Title: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- Patient demographic information
- Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- Supporting clinical notes and office visits. Two notes preferred.
 - Note should include any therapies tried/failed, and must include discussion about Leqvio
 - Medication list and allergies
- Supporting lab reports for Leqvio treatment
 - Baseline LDL
- Leqvio Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com



Prescribing Order: LEQVIO

Date of Order: _____

New Start Maintenance

Date of last injection: _____

Patient Name: _____

DOB: _____

M/F: _____

Diagnosis (include ICD-10 code/s): _____

NKDA Allergies: _____

Patient Weight: _____

Premedication:

Acetaminophen 1000mg PO
 Loratadine 10mg or Cetirizine 10mg PO

Diphenhydramine 25mg PO
 Other: _____

Lab Orders:

LEQVIO Medication Order

Dosing: LEQVIO 284mg/1.5ml SQ Injection

Frequency: Initial dose, again at 3 months Maintenance dose every 6 months

Administration:

- ✓ Administer subcutaneously in the abdomen, upper arm, or thigh. Do not inject in areas of active skin disease or injury, such as sunburns, skin rashes, inflammation, or skin infections.
- ✓ In case of suspected reaction, notify physician.

Ordering Provider Name

NPI

Signature

Date