

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION			
Name:		DOB:	
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
DIAGNOSIS AND ICDE 10 CODE			
<input type="checkbox"/> Heterozygous Familial Hypercholesterolemia (HeFH)		ICD 10 Code: E78.01	
<input type="checkbox"/> Clinical Atherosclerotic Cardiovascular Disease (ASCVD)		ICD 10 Code: 125.10	
<input type="checkbox"/> Hyperlipidemia		ICD 10 Code: E78.5	
<input type="checkbox"/> Other:		ICD 10 Code:	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> The signed order form by the provider		<input type="checkbox"/> Clinical/Progress notes (must be within 1 year)	
<input type="checkbox"/> Patient demographics AND insurance information		<input type="checkbox"/> Lipid Panel	
<input type="checkbox"/> Prior authorization with reference number		<input type="checkbox"/> Verification/documentation that LDL-C has not reached the target of <70mg/dl	
*Pt may be required to submit a pregnancy test prior to treatment			
CURRENT AND PREVIOUS LIPID LOWERING THERAPY—SELECT ALL THAT APPLY			
<input type="checkbox"/> Atorvastatin (Lipitor)----- <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 -----Dates/Length of use: _____			
<input type="checkbox"/> Pravastatin (Pravachol)----- <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 -----Dates/Length of use: _____			
<input type="checkbox"/> Simvastatin (Zocor) ----- <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 -----Dates/Length of use: _____			
<input type="checkbox"/> Rosuvastatin (Crestor) ----- <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 -----Dates/Length of use: _____			
<input type="checkbox"/> Ezetimibe (Zetia) ----- <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 -----Dates/Length of use: _____			
<input type="checkbox"/> Patient had inadequate response to maximally tolerated lipid-lowering therapy			
MEDICATION ORDERS			
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders			
Medication	Dosing/Diluent	Route	Administration
<input type="checkbox"/> J1306 Leqvio	284mg/1.5ml prefilled syringe	Sub-Q injection	Initial dose, 3month and 6 months
Maintenance Dosing			
<input type="checkbox"/> J1306 Leqvio	284mg/1.5ml prefilled syringe	Sub-Q injection	Every 6 months
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses			
PREMEDICATIONS/ LAB ORDERS			
<input type="checkbox"/> Acetaminophen _____ mg PO PRN		<input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____	
<input type="checkbox"/> Benadryl _____ mg PO or IV		<input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____	
<input type="checkbox"/> Methylprednisolone _____ slow IV push		<input type="checkbox"/> Other: _____ Date: _____	
<input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS/INFORMATION			
PRESCRIBER INFORMATION			
Provider Name:			
Office Phone:		Office Fax:	Office Email:
Prescriber Signature:		Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – LEQVIO (INCLISIRAN)