





2301 Evesham Road - Building 800, Suite 115 Voorhees, New Jersey 08043 T. (856) 996-0145 F.(856)770-8271 attn: Josie R

MEDICATION REQUESTED			
DATE:			
NAME OF DRUG BEING REQUESTED:LEQVIO (IDYLLIC will be responsible for providing requested drug)			
REFERRING PROVIDER INFORMATION			
Requesting Provider Name and NPI Tax ID#	Name: NPI: Tax ID#		
Phone Number			
Fax Number			
Practice Contact (Name/Extension)	Phone Number: Ext:		
We will gladly remind your patient to schedule routine follow-up visits with your office.			
Return to Referring Provider (frequency): EVERY WKS / MOS			
PATIENT INFORMATION			
Patient Name			
Date of Birth	/ /		
Height/Weight			
Preferred Treatment Location	☑ Voorhees		
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:		





## ALL OF THE FOLLOWING INFORMATION IS REQUIRED:

Is		is the first injection of Leqvio? YES
		No. Date of last injection:
Pr	ima	ry DX Code?
		E78.02
		I25.10
		Documentation of statin currently being used with start date or
		documentation of statin intolerance.
		Please attach a copy of medication order to this document when
		transmitting to ARBDA/IDYLLIC. Prescription should include
		standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT
		provide a prescription to the patient as they may become confused
		and attempt to fill at their local/specialty pharmacy.
		Copy of Primary and Secondary Medical/Pharmacy Insurance Cards
		(Please enclose both FRONT & BACK)
		History of Infusion / Injection treatments (if applicable) and
		summary of medical history / treatment plan. History must
	_	support DX code checked above.
	_	MOST RECENT and/or Qualifying Labs (based on specific drug)
		Must include a LIPID Panel (Initial dose requires LIPID within 30 days)
		Verification that your patient was issued a RX by the referring
		provider for an EpiPen and that patient was instructed to bring
		the EpiPen with them to the injection/infusion appointment (if
		required).
		Please notify your patient that our office will contact them when
		we are ready to schedule. They do NOT need to call our office to
		<pre>set up an appointment. Does this patient require premedication(s)? If so, please</pre>
	_	document premedication requirements.
		Is this patient ambulatory Yes / NO
		☐ Is a wheelchair required Yes / NO

## PLEASE NOTE:

- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.
- -Please contact our office if medication will be discontinued.

**ARBDA/IDYLLIC NPI:** 1427622661 **TAX ID:** 85-1604336