Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Leqvio Request Form

2301 Evesham Road, Building 800, Suite 115

Voorhees, New Jersey 08043
T. (856) 996-0145
F.(856) 770-8271 attn: Stephanie D

MEDICATION REQUESTED	
DATE:	
NAME OF DRUG BEING REQUESTED:	**LEQVIO**
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	/ /
Insurance(s): include copies of front and back	
Preferred Treatment Location	☒ Voorhees ☒ Moorestown ☒ Wall/Manasquan ☒ Sewell ☒ Hamilton ☒ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

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Name (last, first) _____DOB: _____

ALL OF THE FOLLOWING INFORMATION IS REQUIRED :

Primary DX:
E78.01 Familial hypercholesterolemia
E78.41 Elevated Lipoprotein(a)
E78.49 Other hyperlipidemia, familial combined

Secondary DX is required:
I25.10 ASCVD native CA w/o angina pectoris
I25.110 ASCVD Native CA w/angina pectoris
I25.111 ASCVD native CA w/angina w/spasm
I23.7 Postinfarction angina
I25.84 Coronary atherosclerosis due to lipid rich plaque

- Was the patient on max statin at least 3 months? _____ Start date?_____Will they continue concurrently?_____
- Was the patient's LDL equal to or greater than 190 mg/dL prior to antihyperlipidemic agents? _____
- Does the patient have a statin intolerance?_____ Is statin therapy contraindicated? _____ Specify intolerance_____
- Recent Comprehensive lipid panel. Statin history and/or intolerance documentation
- Will the patient be taking a PCSK9 inhibitor concurrently while on Leqvio? _____
- Was the patient on a PCSK9 inhibitor for at least 3 months? _____ If yes, which one?_____ Did they fail on a PCSK9 inhibitor? _____ Are there any PCSK9 inhibitor contraindications? ____
- Was the patient on Ezetimibe for at least 3 months? _____ Did they fail? ___ Contraindications?____
- History of Infusion / Injection treatments (if applicable).
- Does this patient require premedication(s)? If so, please document premedication requirements.
  - _____
- Is this patient ambulatory ? _____
  - If no, is a wheelchair required _____

PLEASE NOTE:

- 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.
- *Include recent chart notes, all relevant scans, tests and lab results*
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- 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 set up an appointment.
- *-Please notify our office if medication will be discontinued.*

Ordering Provider Signature: _____