



<b>Primary Care Physician (Name / Phone Number)</b>	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? \_\_\_\_\_
- Reason for PCSK9i failure (circle one) intolerance, non-compliance, inability to self-inject, LDL level not at goal.
- 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: \_\_\_\_\_