

Leqvio Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)-497-0905
F.(609)228-9798 attn: Idyllic Infusion Coordinator

Is this a Continuation of Care or a new start to the medication?

- ☐ Continuation of Care (Provide documentation of last administration)
☐ New Rx

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:
Email of Contact	
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 ☐ Sewell ☐ Brick ☐ Hamilton ☐ Galloway ☐ Haddon Heights

Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:
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The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Name (last, first) _____ DOB: _____

ALL OF THE FOLLOWING INFORMATION IS REQUIRED :

Primary DX:

E78.00 Pure hypercholesterolemia, unspecified
E78.2 Mixed hyperlipidemia
E78.4 Other hyperlipidemia
E78.49 Other hyperlipidemia, familial combined
E78.5 Hyperlipidemia, unspecified
E78.01 Familial hypercholesterolemia
E75.5 Other lipid storage disorders

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
I25.118 ASCVD native CA w/other forms of angina
I25.119 ASCVD native CA w/unspecified angina
OTHER: _____

- 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.*

☐ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: _____