AYSA
THERAPEUTICS INFUSION

LEQVIO (INCLISIRAN)
ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: _____ ICD-10 Code: _____

Patient Weight: _____ lbs. Allergies: _____

☐ LDL-C lab attached

☐ Current Cholesterol Medications: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

LEQVIO INJECTION

SELECT ONE:

☐ 284mg subcutaneously initially, again at 3 months, and then every 6 months (initial start)

OR

☐ 284mg subcutaneously every 6 months

** Once we receive all necessary documentation, we will schedule the patient's treatment.

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____