Lincoln Medical Center
*OUTPATIENT INFUSION CENTER*
**Phone: 931-438-1100**
**Fax: 1-931-438-1219**

# LEQVIO ORDER FORM

Patient name: _____ DOB: _____ Sex :( ) Male ( ) Female

SSN:_____ HT: _____ WT: _____ Allergies:_____

Street Address_____ City/State/Zip _____

Home Phone #: _____ Work #: _____ Cell #: _____

## Insurance Information:

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

## Physician Information:

Physician's Name:_____ Referral Contact Name: _____ Phone: _____

Address:_____City/State/Zip_____

DEA#:_____ NPI #:_____ Fax #: _____

State License #: _____

## Statement of Medical Necessity

Primary Diagnosis: (ICD-10 Code plus Description)_____

Date of Diagnosis: _____

Access: Does the patient have venous access? ☐Yes ☐ No If Yes, what type? _____

## Orders:

**Leqvio 284mg/1.5mL subcutaneously**

- ☐ **Initial**
- ☐ **3 months**
- ☐ **Every 6 months X 1 year**

## Include copies of the following with the order:

- LDL, HDL and triglycerides
- Office notes supporting the diagnosis
- H&P dated within the last 2 years
- Prior/current medications used to treat the diagnosis

**Physician's Signature** _____**Date**_____ **Time:**_____

**Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.**
**PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.**