INTRAMED Plus
infusion services

LEQVIO®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis:

_____ Atherosclerosis and atherosclerotic heart disease	IDC-10 Code: I25._____
_____ Disorders of lipoprotein metabolism and other lipidemias	IDC-10 Code: E78._____
_____ Familial hypercholesterolemia (eg, HeFH, HeFH)	ICD-10 Code: E78.0__
_____ Family history of familial hypercholesterolemia	ICD-10 Code: Z83.42
_____ Other: _____	ICD-10 Code: _____

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical Notes & labs supporting primary diagnosis
- Recent Lab Results including a baseline lipid panel
- Medication List
  - Include all cholesterol therapies trialed as well as documentation of efficacy, treatment failures and or intolerances to any agents

Patient
Weight: _____ lbs.
Height: _____ in.

Infusion Center: Lab Orders: (Check order for Infusion Center to manage):

❑ Obtain fasting lipid panel every_____months

LEQVIO® (inclisiran) J Code: J1306

4. Drug Order:

❑ **New Start** 3 (Three) Doses Authorized
Administer 284 mg subcutaneously initially, again at 3 months and then every 6 months

❑ **Maintenance Regimen** _____# Refills (Recommend 1 Refills)
Administer 284 mg subcutaneously every 6 months

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**

OCT 2025