# Hypercholesterolemia

**Call: (877) 883-1392 Fax: (256) 429-2221**

**Patient Information** Name: _____ DOB: _____ Gender: M◯ F ◯

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Caregiver: _____

Email: _____ Height: _____ Weight: _____

Allergies: ◯ No Known ◯ See Attached Charts ◯ Other: Last 4 of SSN: _____

**Prescriber Information** **Please include front and back copies of insurance card.**

Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

## Statement of Medical Necessity (Please attach all medical documentation)

**Primary ICD-10-CM Diagnosis Code:**

◯ E78.00 Pure hypercholesterolemia, unspecified

◯ E78.01 Familial hypercholesterolemia

◯ E78.2 Mixed hyperlipidemia

◯ E78.49 Other hyperlipidemia, familial combined hyperlipidemia

◯ E78.5 Hyperlipidemia, unspecified

◯ E78.9 Disorder of lipoprotein metabolism, unspecified

◯ Other: _____

**Secondary ICD-10-CM Diagnosis Code**

◯ Secondary Code: _____

**Include patient chart notes to support documentation payers may require, such as:**

* Clinical documentation for specified ICD-10-CM diagnosis code
* Recent comprehensive lipid panel/LDL-C values (in the last 90 days)
* Statin history and/or additional lipid-lowering treatment
* Statin intolerance (if applicable)
* Counseling on the importance of lifestyle modifications including diet and exercise

## Prescription Information (Please be sure to choose both induction and maintenance dose when applicable)

| Medication | Dosage & Strength | Instructions | Quantity | Refill |
|---|---|---|---|---|
| ◯ Leqvio | ◯ 284 mg/1.5mL Prefilled Syringe | ◯ Initial Dose: Inject 284mg/1.5mL SC initially, then 284mg/1.5mL SC in 3 months<br>◯ Maintenance Dose: Inject 284mg/1.5mL SC every 6 months | | |

**Prescriber Signature** (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.)

Signature: _____ Date: _____

**Substitution Permitted**

Signature: _____ Date: _____

**Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.