

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:

Secondary 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 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
<input type="radio"/> Leqvio	<input type="radio"/> 284 mg/1.5mL Prefilled Syringe	<input type="radio"/> Initial Dose: Inject 284mg/1.5mL SC initially, then 284mg/1.5mL SC in 3 months <input type="radio"/> 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.

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