

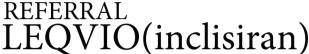
Q	175MemorialHighway.Suite1-1
	NewRochelle,NY
	1090

C	914-460-489	
	fue of the sim	

ok the switch to biosimilar if insurance formulary prefers

\checkmark	fuse@fuseinfusion.com

■,	914-460-4571



REFERRAL	Date:
LEQVIO(inclisiran)	
	IT INFORMATION
Name:	DOB:
Allergies:	Date of Referral:
REFER	RAL STATUS
□New Referral □Referral Renewal □Medication/Order	Change ☐ Benefits Verification Only ☐ Discontinuation Order
LEQVIO Injection*: (SELECT ONE OF THE FOLLOWING)	
Dosing: 284 mg subcutaneously Injection	
*Frequency: initial dose, again at 3 months, then ev	very 6 months
Physician Signature* Date*(Order * NPI#	is Valid for One Year)
REQUIRED DIAGNOSIS:	REQUIRED DOCUMENTATION CHECKLIST:
heterozygous familial hypercholesterolemia (HeFH)	Patient Demographics
clinical atherosclerotic cardiovascular disease (ASCVD)	Insurance Card/Information
Other	Clinical/Progress Notes supporting DX
	Current Medication List and H&P
Last Infusion/Injection Date:	
	MPP USE ONLY
Referral Reviewed and Accepted by:Additional information needed/ notes:	Date approved:
RDERING PROVIDER	

Provider _____ Phone ____ Fax _____

Signature X Date