Leqvio Order Form

Select patient referral location: Anchorage Palmer Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: M F	Weight:

Patient Status: New to therapy Continuing therapy Next due date *(if applicable)*:

2. PHYSICIAN INFORMATION

Physician's Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION *(and year of diagnosis)*

(HeFH) Heterozygous Familial Hypercholesterolemia (**ICD 10** _______) (ASCVD) Atherosclerotic Cardiovascular Disease (**ICD 10** _______)

Other *(specify)*: ____ **ICD 10** (_______)

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION *(requires new order every 12 months)*

LEQVIO
Administer 284mg SubQ initially, again at 3 months,
then Q 6 months

Vital signs per LUX Protocol
Anaphylaxis & Hydration Management per LUX Protocol

6. SIGNATURE *(required)*

PHYSICIAN'S SIGNATURE DATE

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