

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Most Recent Office Visit Note, Insurance Information

PATIENT INFORMATIONReferral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code: Primary Diagnosis: E75.5 E78. _____ ICD Description: _____
(required)AND Secondary Diagnosis: I2 . ____ I6 . ____ I7 . ____ E11. ____ N18. ____ I10. ____ Z83.42

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____**PROVIDER INFORMATION**

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

NURSING

-
- Center will use Hypersensitivity protocol established by Infusion for Health and PI

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

-
- Diphenhydramine
-
- 25mg /
-
- 50mg
-
- PO /
-
- IV
-
-
- Acetaminophen
-
- 325mg /
-
- 500mg /
-
- 650mg PO
-
-
- Other: _____
-
- Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:**LABORATORY ORDERS**

-
- CBC
-
- at each dose
-
- every _____
-
-
- CMP
-
- at each dose
-
- every _____
-
-
- Other: _____
-
- Frequency: _____
-
-
- Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

-
- Leqvio Subcutaneous Injection
-
- Dose: 284mg (pre-filled syringe)
-
- Frequency:
-
-
- Initial dose, again at 3 months, then every 6 months
-
-
- Maintenance every 6 months
-
-
-
- Refills:
-
- Zero /
-
- for 12 months /
-
- _____
-
- (if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) _____ Provider Signature _____ Date _____

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- Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.