

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; Recent Lipid Panel

PATIENT INFORMATIONReferral Status: New Referral Updated Order Order Renewal

Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code: Primary Diagnosis: E78.00 E78.2 E78.49 E78.5 E78.011 E78.019 ICD Description: _____
(required)

AND Secondary Diagnosis: _____

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

- Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions

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.

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

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

SPECIAL INSTRUCTIONS:**THERAPY ADMINISTRATION**

- Leqvio subcutaneous injection
 Dose: 284mg
Frequency (choose one):
 Initial dose, another dose at 3 months, then every 6 months
 Every 6 months (select if patient is continuing therapy)
 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 _____

- 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.