



# Leqvio Referral Form

Please fax completed referral form to  
Avant Wellness, PLLC

**(980)446-1445**

Please contact office for questions:

**(980)446-1444**

PATIENT DEMOGRAPHICS:	
PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	GENDER: <input type="checkbox"/> F <input type="checkbox"/> M
	CITY, STATE, ZIP:

**PRIMARY DIAGNOSIS:** PLEASE PROVIDE ICD-IO CODE

E78.01 - Familial Hypercholesterolemia     Z83.42 - Family History of Familial Hypercholesterolemia

I25.10 - Atherosclerotic Heart Disease of native coronary artery without angina pectoris     OTHER: \_\_\_\_\_

**REQUIRED DOCUMENTATION:** PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

1. INSURANCE CARD (Front & Back)     2. PATIENT DEMOGRAPHICS     3. MOST RECENT LABS     4. H & P

DOCUMENTATION OF ALL PREVIOUSLY ATTEMPTED THERAPIES, INTOLERANCES, OR CONTRAINDICATIONS

**MEDICATION SELECTION:**

	<input type="checkbox"/> INDUCTION: 284mg subcutaneous injection at day 0, month 3, and every 6 months thereafter    REFILLS: <u>  1yr  </u>
	<input type="checkbox"/> MAINTENANCE: 284mg subcutaneous injection every 6 months    REFILLS: <u>  1yr  </u>

**PRESCRIBER INFORMATION:**

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:
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