Wellspring Health
INFUSION CENTER

Please fax completed forms to Wellspring Health at **(563) 900-8290**

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis:

☐ Pure hypercholesterolemia, unspecified (ICD-10: E78.00)
☐ Familial hypercholesterolemia (ICD-10: E78.01)
☐ Mixed hyperlipidemia (ICD-10: E78.2)
☐ Hyperlipidemia, unspecified (ICD-10: E78.5)
☐ ASCHD w/o angina pectoris (ICD-10: I25.10)
☐ Other: _____ ICD-10: _____

LEQVIO® (inclisiran) injection 284 mg/1.5 mL

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Leqvio - *choose one:*

☐ 284mg subcutaneously initially, at 3 months, and then every 6 months (initial start) x 1 year

☐ 284mg subcutaneously every 6 months x 1 year

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____
Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____
☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

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