Mercy LTC & Specialty Pharmacy
A Member of Mercy Pharmacy Group

FAX: 562.402.4629

Lipid Management

Version: 9/9/2026

PATIENT INFORMATION

Patient Name		Phone Number	
Date of Birth	◯ Male ◯ Female	Allergies	Email
Address		City, State, Zip Code	

CLINICAL INFORMATION - PRIMARY DIAGNOSIS

◯ ***E78.01: Familial Hypercholesterolemia***
◯ ***E78.2: Mixed hyperlipidemia***
◯ ***E78.00: Pure hypercholesterolemia, unspecified***
◯ **E78.49: *Other hyperlipidemia***
◯ ***E78.5: Hyperlipidemia, unspecified***
◯ ***Other IDC-10 with description:*** _____
◯ ***I25.10 Atherosclerotic Heart Disease of native coronary artery without angina pectoris***

LEQVIO (INCLISIRAN)

◯ **Initial: Inject 284 mg subcutaneously on month 0, 3, then every 6 months x 1 year.**
◯ **Maintenance: Inject 284 mg subcutaneously every 6 months x 1 year**

Please provide the following:

◯ Lipid Panel
◯ Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.

TREATMENT SITE LOCATION

◯ Deliver to MDO
◯ Inject at Mercy AIS

PHYSICIAN INFORMATION

Physician Name	**DEA #**	**NPI #**	**License #**
Address	**City, State, Zip Code**		
Phone	**Fax**	**Office Contact**	

By signing this form, you are authorizing Mercy LTC & Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

MD Signature: _____ **Date:** _____