Inclisiran (Leqvio)

Provider Order Form rev. 09/19/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

PRIMARY DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Mixed Hyperlipidemia: Hyperlipidemia (unspecified):

Pure Hypercholesteremia: Other Hyperlipidemia:

Disorder of lipoprotein metabolism: Familial Hypercholesterolemia:

Other hyperlipidemia:

Other: Description:

SECONDARY DIAGNOSIS *(Required)*

Type 2 diabetes Mellitus: Primary hypertension:

ASCVD: CKD: Family history of familial hypercholesterolemia:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Administer Leqvio 284mg subcutaneous injection in upper arm, abdomen, or upper thigh.

☑ Monitor patient for post injection observation period of 15mins after first injection. If no reaction occurs, no further observation period is required.

FREQUENCY *(Choose one)*

☐ Induction: month 0, month 3, then every 6 months

☐ Maintenance: every 6 months

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- abnormal vital signs or chance of pregnancy

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with statins, Repatha or Praluent, and Zetia, Allergies, History of MI, CAD, stroke, TIA, or cardiac surgery ***(If Applicable).***

Required Labs: LDL, and cholesterol levels

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.