Inclisiran (Leqvio)

Provider Order Form rev. 10/20/2025

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)***

- ☐ E78.00: Pure hypercholesterolemia unspecified
- ☐ E78.011: Heterozygous Familial Hypercholesterolemia
- ☐ E78.2: Mixed Hyperlipidemia
- ☐ E78.019: Familial Hypercholesterolemia, Unspecified
- ☐ E78. ___: Disorders of lipoprotein metabolism
- ☐ Other: Description:
- ☐ E78.5: Hyperlipidemia, unspecified

SECONDARY DIAGNOSIS ***(Required. Please provide ICD-10 code in space provided)***

- ☐ I10. ___: Primary Hypertension
- ☐ I25. ___: ASCVD
- ☐ I63. ___: Cerebral Infarction
- ☐ Z83.42: 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

LABORATORY ORDERS

☐ Other: _____

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.