

## LEQVIO (INCLISIRAN) ORDER FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

### PRIMARY DIAGNOSIS (Provider must specify)

Disorders of lipoprotein metabolism, ICD 10: E78. \_\_\_\_\_

Other: \_\_\_\_\_

### SECONDARY DIAGNOSIS

Atherosclerotic Heart Disease, ICD 10: I25. \_\_\_\_\_  Ischemic Heart Disease, ICD 10: \_\_\_\_\_

Other: \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

Demographics  Labs and tests supporting diagnosis  Office/progress notes  Start form completed

### PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO  Famotidine 20 mg IV  Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO  Cetirizine (Zyrtec) 10 mg PO

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Leqvio	<input type="checkbox"/> 284 mg	<input type="checkbox"/> Subcutaneous Inj.	<input type="checkbox"/> Month 0, 3, then repeat every 6 months <input type="checkbox"/> Every 6 months

New Start Therapy  Continuation of Therapy Date of last dose (if applicable): \_\_\_\_\_

### LABS / SPECIAL INSTRUCTIONS