

LEQVIO (INCLISIRAN) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 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

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	284 mg	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

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> CT: 203.433.0621 | <input type="checkbox"/> MA: 413.296.8482 | <input type="checkbox"/> NC: 919.984.8698 | <input type="checkbox"/> NY: 631.250.6020 | <input type="checkbox"/> SC: 864.973.6279 |
| <input type="checkbox"/> FL: 904.877.9270 | <input type="checkbox"/> MD: 240.224.8607 | <input type="checkbox"/> NH: 603.217.5371 | <input type="checkbox"/> OH: 937.871.4594 | <input type="checkbox"/> VA: 703.202.0499 |
| | <input type="checkbox"/> ME: 207.407.7272 | <input type="checkbox"/> NJ: 201.581.4521 | <input type="checkbox"/> PA: 610.273.5998 | |