Local Infusion

MYLOCALINFUSION.COM

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._____ ❑ Iscemic 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	❑ 284 mg	❑ Subcutaneous Inj.	❑ Month 0, 3, then repeat every 6 months ❑ Every 6 months

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ CT: 203.433.0621 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

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