



Leqvio Order Form (inclisiran)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____
 Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

Primary:

- E78.00 Pure hypercholesterolemia, unspecified
- E78.01 Familial hypercholesterolemia
- E78.2 Mixed hyperlipidemia
- E78.49 Other hyperlipidemia, familial combined hyperlipidemia
- E78.5 Hyperlipidemia, unspecified
- E78.9 Disorder of lipoprotein metabolism, unspecified

AND

Secondary:

- I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
- Other: _____

Prescribing Information

If a dose is missed by <3 months from the usual day of administration, administer the dose as soon as possible and then resume the original schedule. If a dose is missed by >3 months, skip the missed dose and restart with a new dosing schedule as initial dose, then again at 3 months, and then every 6 months.

REQUIRED: Demographics & Most Recent: H&P, clinical notes supporting CVD, & medication list including documentation of current statin therapy or intolerance to use. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy. For HeFH include Dutch Lipid Clinic Network Criteria and/or Simon-Broome Diagnostic Criteria assessment.
LAB RESULTS: Baseline Lipid Panel; For HeFH include labs to confirm genetic mutation analysis.

PRESCRIPTION

Leqvio (inclisiran)

Loading Dose:

SubQ: Inject 284 mg at week 0, at 3 months

Maintenance:

SubQ: Inject 284 mg every 6 months for one year

Has patient received any doses?

1st Date _____
 2nd Date _____

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following loading dose, 15 minutes on subsequent doses.

Comments:

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI #: _____ Specialty: _____
 Supervising Physician: _____ (If Applicable)
 Address: _____ City: _____ State: _____ Zip: _____
 Contact Name: _____ Phone: _____ Fax: _____ Email: _____