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: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

PRIMARY ***AND*** **SECONDARY**

☐ 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

☐ 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 Dose

☐ **SubQ:** Inject 284 mg every 6 months for one year

Has patient received any doses?

☐ 1st Date _____

☐ 2nd Date _____

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

If yes, please note therapy and last dose: _____

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

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

Date of last dose: _____

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____