

Inclisiran (Leqvio)

Provider Order Form rev. 1/23/2025



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name:	DOB:	Patient Phone:	
Patient Address:	Patient Email:		
Allergies:	<input type="checkbox"/> NKDA	Weight (lbs/kg): Height (in/cm):	
Sex: <input type="checkbox"/> M / <input type="checkbox"/> F	Date of Last Infusion:	Next Due Date:	Preferred Location:

PRIMARY DIAGNOSIS (Please provide ICD-10 code in space provided)

<input type="checkbox"/> E78.00: Pure hypercholesterolemia unspecified	<input type="checkbox"/> E78.01: Heterozygous Familial Hypercholesterolemia
<input type="checkbox"/> E78.2: Mixed Hyperlipidemia	<input type="checkbox"/> E78.5: Hyperlipidemia, unspecified
<input type="checkbox"/> E78. __: Disorders of lipoprotein metabolism	<input type="checkbox"/> Other: Description:

SECONDARY DIAGNOSIS (Required. Please provide ICD-10 code in space provided)

<input type="checkbox"/> I10. __: Primary Hypertension	<input type="checkbox"/> I25. __: ASCVD
<input type="checkbox"/> I63. __: Cerebral Infarction	<input type="checkbox"/> Z83.42: Family history of familial hypercholesterolemia
<input type="checkbox"/> Other: Description:	

THERAPY ADMINISTRATION & DOSING

- Administer Leqvio 284mg subcutaneous injection in upper arm, abdomen, or upper thigh.
- Monitor patient for post injection observation period of 15mins after first injection. If no reaction occurs, no further observation period is required.

FREQUENCY (Choose one)

- Induction: month 0, month 3, then every 6 months
- Maintenance: every 6 months

ADDITIONAL ORDERS

LABORATORY ORDERS

Other: _____

PRE-MEDICATION ORDERS

Other: _____

NURSING

- Hold infusion and notify provider for:
 - abnormal vital signs or chance of pregnancy
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name:	Preferred Contact Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with statins, Repatha or Praluent, and Zetia, Allergies, History of MI, CAD, stroke, TIA, or cardiac surgery (If Applicable).

Required Labs: LDL, and cholesterol levels

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.