# Inclisiran (Leqvio)

**Provider Order Form rev.** 10/20/2025

## PATIENT INFORMATION

**Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

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

- ☐ E78.00: Pure hypercholesterolemia unspecified
- ☐ E78.011: Heterozygous Familial Hypercholesterolemia
- ☐ E78.2: Mixed Hyperlipidemia
- ☐ E78.019: Familial Hypercholesterolemia, Unspecified
- ☐ E78. ___: Disorders of lipoprotein metabolism
- ☐ Other: Description:
- ☐ E78.5: Hyperlipidemia, unspecified

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

- ☐ I10. ___: Primary Hypertension
- ☐ I25. ___: ASCVD
- ☐ I63. ___: Cerebral Infarction
- ☐ Z83.42: Family history of familial hypercholesterolemia
- ☐ 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.

**Disclaimer**: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial

assistance programs, as requested.