LEQVIO
(inclisiran)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:______________lbs or ___________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies

- Are LDL levels elevated? ☐Y ☐N
- ASCVD Risk Score:__________
- Current Lipid Lowering Regimen: ________________

PRIMARY DIAGNOSIS

☐ E78.00 Pure hypercholesterolemia, unspecified
☐ E78.01 Familial hypercholesterolemia
☐ E78.2 Mixed hyperlipidemia
☐ E78.5 Hyperlipidemia, unspecified
☐ I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
☐ Other: ________________________________

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ________________________________

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PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Leqvio
☐ Provider Prescribed: ____

____

PRIMARY MEDICATION ORDER

☐ Leqvio 284mg SubQ at day 0, month 3, and every 6 months thereafter
☐ Leqvio 284mg SubQ every ______months
☐ Other:____

First Dose: ☐Y ☐N ☑ Refill x12 months unless otherwise noted:______________________________

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Infusion Specialists' protocol
(See infusionspecialist.org for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

______________________________________ ____________________
Provider Signature Date

infusion SPECIALISTS