Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

Leqvio (inclisiran)
SubQ Injection Orders

Required Information:

☐ Signed order from prescribing provider

☐ Patient demographics including insurance information

☐ Supporting clinical documentation: Visit notes, diagnostic results

☐ Required Labs: **Lipid Panel within last 3 months**

☐ **Primary Diagnosis:**

_____(ICD-10 :_____)

☐ **Secondary Diagnosis:**

_____**(**ICD-10:_____)

Other:_____**(**ICD-10:_____**)**

LEQVIO ORDERS

☐ **Leqvio 284mg SubQ initially, again at 3 months, and then every 6 months**

☐ **Leqvio 284mg SubQ every 6 months** **Date of Last Leqvio: _____**

Administered per manufacturer guidelines

PRE-MEDICATIONS

☐ PO Tylenol _____mg

☐ PO Cetirizine _____mg

☐ IV Solu-medrol _____mg

☐ PO Loratadine _____mg

☐ PO ☐ IV Diphenhydramine _____mg

☐ PO ☐ IV Other:_____ _____mg

LABS

☐ CBC ☐ ESR ☐ Uric Acid

☐ CMP ☐ TB Quantiferon Gold ☐ Other:_____

☐ CRP ☐ Hep B Core/Surface AG ☐ Other:_____

Frequency:

☐ Every Visit

☐ Every Other Visit

☐ One time only

☐ Other:_____

CPL Acct #:_____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

_____

_____

_____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**