



Nucara Pharmacy Nucara Infusion Center
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Austin, TX 78757 Austin, TX 78757
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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

Frequency:

Every Visit

CMP

TB Quantiferon Gold

Other: _____

Every Other Visit

CRP

Hep B Core/Surface AG

Other: _____

One time only

Other: _____

CPL Acct #: _____

ADDITIONAL INSTRUCTIONS

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

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