

LEQVIO® (inclisiran)


Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
DOB: _____ Allergies: NKDA _____
Phone Number: _____
Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____


Required Documentation

- Patient Demographics and Insurance Card Medication List
 Clinical/Progress Notes Supporting Dx LDL-C

Primary Diagnosis

-  ICD-10 Code (required): _____
 Familial Hypercholesterolemia
 Clinical atherosclerotic cardiovascular disease (ASCVD)
 Hyperlipidemia
 Other: _____

Therapy Administration

- Induction: Leqvio 284mg subcutaneously initially, at 3 months, and then every 6 months
 Maintenance: Leqvio 284 mg every 6 months
 Other: _____
- Refills:**
 x 1 year Other: _____
-  Order valid for one year unless otherwise stated
- Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to administer ordered therapy per manufacturer guidelines.
 Other: Please fax alternative reaction orders or nursing administration orders if checking this box

Special Orders

Provider Information

Provider Name: _____ Office Contact Person: _____
Referring Practice Name: _____ Phone Number: _____
Referring Practice Address: _____ Fax Number: _____
City, State, Zip: _____ Email: _____
Provider NPI: _____
Provider Signature: _____ Date: _____