

LEQVIO

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ E78.5 (Hyperlipidemia, unspecified) ☐ E78.01 (Familial Hypercholesterolemia)
☐ I25.____ (ASCVD)

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

Current Statin therapy: _____

TREATMENT

LEQVIO (inclisiran)

Route: Subcutaneous injection

Dose: ☐ 284mg

Frequency:

- ☐ Induction: Once in day 0 and
at 3 months
☐ Maintenance: Every 6 months

Quantity: _____ Refills: _____

Premedication Protocol: *(Not Usually Indicated)*

- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO
☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity protocol
established by Cure Stat Infusion Services.

Special Instructions: _____

Provider Signature: _____

Date: _____