LIFE SPECIALTY SOLUTIONS

LEQVIO
(inclisiran)

PATIENT INFORMATION

PATIENT NAME: ______ PHONE #: ______

ADDRESS: ______ CITY, STATE, ZIP: ______

DATE OF BIRTH: ______ EMAIL: ______

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card
2. History & Physical
3. Patient Demographics
4. Medication List
5. Tried/Failed Therapies
6. Most Recent Labs
7. Are LDL levels elevated? ☐ Yes ☐ No
8. ASCVD Risk Score ______
9. Current Lipid Lowering Regimen______

PRIMARY DIAGNOSIS

☐ E78.00 Pure hypercholesterolemia, unspecified

☐ E78.2 Mixed hyperlipidemia

☐ I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris

☐ E78.010 Homozygous familial hypercholesterolemia [HoFH]

☐ E78.011 Heterozygous familial hypercholesterolemia [HeFH]

☐ E78.019 unspecified

☐ E78.5 Hyperlipidemia, unspecified

☐ Other ______

LABS ORDERS: PLEASE INCLUDE FREQUENCY

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

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?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted ______

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: ______ PHONE: ______

OFFICE CONTACT: ______ FAX: ______

ADDRESS: ______ EMAIL: ______

CITY, STATE, ZIP: ______ NPI AND LICENSE: ______

✖ ______ ______

PROVIDER SIGNATURE DATE