

# Leqvio (Inclisiran)

**PATIENT INFORMATION**Referral Status (check one):  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

**PRESCRIPTION****THERAPY ADMINISTRATION**

- Inclisiran** (Leqvio)
- Dose: inclisiran sodium 284mg (pre-filled syringe)
  - Route: subcutaneous injection

Frequency:

- Initial dose, again at 3 months, then every 6 months  
 Maintenance every 6 months

- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

**SPECIAL INSTRUCTIONS****PROVIDER INFORMATION**

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Provider Name (Print)\_\_\_\_\_  
Provider Signature\_\_\_\_\_  
Date