*Patient Insurance & ID (front and back) are needed

LEQVIO (inclisiran)

☐ New Prescription/Referral
☐ Prescription Refill

Of Refills:

Rx:

Patient Name:

Patient Weight: kg

DOB:

Leqvio: (inclisiran)

☐ 284mg SubQ at Day 0, Months 3, and every 6 months (initial start) x 1 year

☐ 284mg subcutaneously every 6 months x 1 year

☐ Others: _____

_____

Pre-Medication:

☐ Solumedrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Others: _____

☐ Tylenol _____ mg PO
☐ 650 mg ☐ 975 mg

☐ Benadryl _____ mg PO
☐ 25 mg ☐ IV
☐ 50 mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

Diagnosis:

☐ Pure hypercholesterolemia, unspecified (ICD-10: E78.00)
☐ Mixed hyperlipidemia (ICD-10: E78.2)
☐ Familial hypercholesterolemia (ICD-10: E78.01)
☐ Hyperlipidemia, unspecified (ICD-10: E78.5)
☐ ASCHD w/o angina pectoris (ICD-10: I25.10)
☐ Other: _____
☐ ICD-10: _____

Physician Signature

NPI #:

DATE:(Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name:

Clinic:

Phone:

Fax:

Email:

Other:

Office Mailing Address:

Please include the following

☐ Patient demographics
☐ Insurance attached
☐ Diagnosis(supporting)
☐ History & Physical
☐ Lab Results
☐ Clinical progress notes
☐ Medication list
☐ Other Test Results
☐ Cholesterol with LDL-C (required)

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.