Leqvio Order
(inclisiran)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information ❒ Current Medications
❒ Lipid Panel ❒ H & P Relevant to Diagnosis

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

LEQVIO (INCLISIRAN) DOSAGE:

Date of Last Treatment, If Continuation:

Dose: **284 mg/1.5mL Pre-Filled Syringe** **Frequency: 0, 3 months, then every 6 months**

Start Date of Infusion: _____ End Date of Infusion: _____

Other Orders or Special Instructions: