

LEQVIO

(inclisiran)

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card	• History & Physical	• Patient Demographics	• Most Recent Labs
• Medication List	• Tried/Failed Therapies	• Lipid Panel	
• Are LDL levels elevated? ☐ Y ☐ N • ASCVD Risk Score: _____ • Current Lipid Lowering Regimen: _____			

PRIMARY DIAGNOSIS

☐ E78.00 Pure hypercholesterolemia, unspecified	☐ I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
☐ E78.01 Familial hypercholesterolemia	☐ Other: _____
☐ E78.2 Mixed hyperlipidemia	
☐ E78.5 Hyperlipidemia, unspecified	

PRE-MEDICATIONS: **No standard premedications typically recommended**

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP	☐ Pepcid 20mg PO or IVP
☐ Solu-Medrol 40mg IVP ☐ Cetirizine 10mg PO	☐ Other: _____
☐ Solu-Medrol 125mg IVP ☐ Tylenol 650mg PO	

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

☐ Leqvio 284mg SubQ at day 0, month 3, and every 6 months thereafter
☐ Leqvio 284mg SubQ every _____ months
☐ Other: _____
First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☒ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)	☐ Other: Please fax other reaction orders if checking this box
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PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature _____

Date _____