



Leqvio Order Form

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

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

ORDER FOR LEQVIO (INCLISIRAN):

- Initial Dose:** 284mg/1.5ml via subcutaneous (SQ) injection at day 0, month 3 and then every 6 months x 1 year
- Maintenance Dose:** 284mg/1.5ml via subcutaneous (SQ) injection every 6 months x 1 year

Admin Instructions: Medication will be administered subcutaneously into the abdomen, upper arm, or thigh

PRE-MEDICATIONS:

- Acetaminophen 650mg PO
- Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- Nevada Infusion Hypersensitivity Reaction Order Set
- Other: _____

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
 Physician Signature: _____ Date: _____
 Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **



Patient Name: _____ DOB: _____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- Signed provider orders (page 1)
- Patient demographic and insurance information
- Patient's current medication list
- Supporting recent clinical notes and H&P (to support primary diagnosis)
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
 - Heterozygous familial hypercholesterolemia (HeFH) - Does the patient have an untreated LDL ≥ 190 mg/dL (≥ 155 mg/dL if < 16 years of age)

Please mark any of the following criteria the HeFH patient meets:

- Family history of Myocardial Infarction (MI) at < 60 years old in 1st degree relative, History of MI at < 50 years old in 2nd degree relative.
- Family history of total cholesterol $>$ than 290mg/dL in a 1st or 2nd degree relative.
- Arcus cornealis before age 45.
- Presence of tendon xanthoma in the patient or 1st or 2nd degree relative.
- ASCVD - Patient's LDL remains ≥ 100 mg/dL despite treatment with a high intensity statin?
- Patient has tried and failed a PCSK9 inhibitor after 12 weeks of use?
- Patient has tried and failed high intensity statin for ≥ 8 continuous weeks?

Please indicate any conditions the patient has:

- Acute Coronary Syndrome
- History of Myocardial Infarction
- Coronary or arterial revascularization
- Stroke
- Transient Ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

Please include labs and tests results to support diagnosis:

- LDL-C (Required)
- Mutation in LDL, apoB, or PCSK9 gene (if/when applicable)

Please list any additional documentation to support medical necessity:

- Other: (please attach results)

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