Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

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. **

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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 ≥190mg/dL (≥ 155mg/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 ≥ 100mg/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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