LEQVIO
(inclisiran)

InfuseAble Care | FLEXCARE INFUSION CENTERS

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

• Are LDL levels elevated? ☐ Y ☐ N • ASCVD Risk Score:_____ • Current Lipid Lowering Regimen: _____

PRIMARY DIAGNOSIS

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

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

*Per infusion clinic protocol, there are no recommended standard pre-meds for Leqvio
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ 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 FlexCare Infusion Centers' protocol
(See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

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 _____

FAX:(480) 400-6121 | EMAIL: referral@infuseablecare.com | VISIT: infuseablecare.com/provider-services/order-forms