Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

P: (360) 933-4892
F: (360) 933-1197
www.infusionsolutionsinc.com

LEQVIO (inclisiran) ORDER FORM

PATIENT NAME: _____ DOB: _____ WT: _____ HT: _____
ALLERGIES: _____

DIAGNOSIS

HAS THE PATEINT PREVIOUSLY RECEIVED: LEQVIO (inclisiran) ❒NO ❒YES - LAST DOSE DATE: _____

DIAGNOSIS: _____ ICD 10 CODE(S): _____

MEDICATION ORDERS

DOSE/FREQUENCY: Orders are valid for 1 year. For a shorter duration, indicate here: _____

- ❒ 284 mg subcutaneously initially, again at 3 months, then every 6 months thereafter
- ❒ 284 mg subcutaneously every 6 months maintenance
- ❒ Other: _____
- If a planned dose is missed by < 3 months, give dose and maintain dosing according to original schedule
- If a planned dose is missed by > 3 months, restart with a new dosing schedule – Give dose initially, again at 3 months and then every 6 months

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- Monitor vital signs (temp, HR, RR, BP) before and after therapy.
- Observe patient for 15 minutes after completion of therapy.

LABS

LAB ORDERS:

- ❒ Lipid panel
- ❒ _____

LAB FREQUENCY:

- ❒ Every 6 months
- ❒ _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- Baseline lipid panel

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- CMP

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution) | *PRESCRIBER SIGNATURE (dispense as written)*

PRINT NAME (FIRST AND LAST) | *DATE*