

LEQVIO

(inclisiran)

FLEXCARE
INFUSION CENTERS**PATIENT DEMOGRAPHICS**

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	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 AND SECONDARY DIAGNOSIS**Primary Diagnosis**

- ☐ E78.00 Pure hypercholesterolemia, unspecified
☐ E78.011 Heterozygous familial hypercholesterolemia [HeFH]
☐ E78.019 Familial hypercholesterolemia, unspecified
☐ E78.2 Mixed hyperlipidemia
☐ E78.4 Other hyperlipidemia
☐ E78.5 Hyperlipidemia, unspecified
☐ Other: _____

Secondary Diagnosis

- ☐ I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
☐ Z95.820 Peripheral vascular angioplasty status with implants and grafts
☐ I10 Essential Hypertension
☐ E11. _____ Diabetes Mellitus
☐ N18. _____ Chronic Kidney Disease
☐ 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:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals

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