aleracare
advanced infusion centers™

FAX 833.329.4738

Leqvio (Inclisiran)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ____________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

E78.00 Pure hypercholesterolemia, unspecified

E78.01 Familial hypercholesterolemia

E78.2 Mixed hyperlipidemia, familial combined hyperlipidemia

E78.49 Other hyperlipidemia, familial combined hyperlipidemia

E78.5 Hyperlipidemia, unspecified

E78.9 Disorder of lipoprotein metabolism, unspecified

Other: ________________________________

Medication Order

Leqvio (Inclisiran) **Dose:** 284mg SC **Frequency:** Give at month 0, 3 then every 6 months thereafter
Every 6 months

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): ________________ (If not indicated order will expire one year from date signature) Check here if this is a stat order