Leqvio Order
(inclisiran)

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:**
☐ Demographics ☐ Insurance Information ☐ Current Medications
☐ Lipid Panel ☐ H&P Relevant to the Diagnosis

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

LEQVIO (INCLISIRAN) DOSAGE:

Date of Last Treatment, If Continuation:

Dose: 284 mg/1.5mL Pre-Filled Syringe **Frequency: 0, 3 months, then every 6 months**

Start Date of Infusion: _____ End Date of Infusion: _____

Other Orders or Special Instructions:

Revised 05/13/22