



6415 Fort Apache Road, Suite #175
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LEQVIO (Inclisiran) Order

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
Gender: _____ Height: _____ Weight: _____ (lb./kg)

Diagnosis

- | | |
|--|---|
| ☐ Pure hypercholesterolemia, unsp | ☐ Hyperlipidemia, unsp |
| ☐ Familial hypercholesterolemia | ☐ Other hyperlipidemia, familial combined |
| ☐ Mixed hyperlipidemia | ☐ Disorder of lipoprotein metabolism, unsp |
| ☐ Other hyperlipidemia | ☐ _____ |

Pre-Medication

- | | |
|--|---|
| ☐ Tylenol 1000mg PO | ☐ Solu-Cortef 100mg IVP |
| ☐ Cetirizine 10mg PO | ☐ Diphenhydramine 25mg IVP |
| ☐ Diphenhydramine 25mg PO | ☐ _____ |
| ☐ Solu-Medrol 125 IVP | ☐ _____ |

Orders

Dosage

- ☐ __284__ mg INITIALLY, AGAIN AT 3 MONTHS THEN EVERY 6 MONTHS THERAFTER
- ☐ __284__ mg EVERY 6 MONTHS (MAINTENANCE DOSE)

_____ Refills

Notes

Ordering Provider

Signature: _____ Date: _____
Provider: _____ Phone: _____ Fax: _____
Address: _____
NPI: _____ DEA: _____