Fax: 561-516-6626 | Email: Info@infuseone.com | Phone: 561-337-4055

(inclisiran)

LEQVIO infusion orders

INFUSE ONE

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Clinical atherosclerotic cardiovascular disease (ASCVD)

☐ _____ Heterozygous familial hypercholesterolemia (HeFH)

☐ _____ _____
(other)

PRE-MEDICATION

☐ Acetaminophen 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____
(other)

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____
(other)

LEQVIO (inclisiran) ORDERS

DOSAGE & FREQUENCY

○ 284mg administered as a single subcutaneous injection initially, again at 3 months, and then every 6 months.

○ _____

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____