Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

INFUSE ONE

Leqvio (Inclisiran) Injection Orders

Patient Name: _____ DOB: _____

Diagnosis (please provide ICD10 code) _____ ☐ Male ☐ Female

☐ NKDA Allergies: _____

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider:

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

LEQVIO (Inclisiran) ORDERS

DOSING:

Inclisiran sodium 284mg (pre-filled syringe)

ADMINISTRATION:

Inject LEQVIO subcutaneously into the abdomen, upper arm, or thigh.

FREQUENCY:

☐ Initial dosing: Week 0, again at 3 months, then every 6 months

☐ Maintenance Dosing: Inject SQ every 6 months

ORDER NOTES:

_____

REQUIRED TESTING/LABS:

☑ Clinical/Progress Notes supporting primary diagnosis (please attach)

☑ Most recent Lipid Panel

☑ Please list previously tried and failed medications (ie maximally tolerated statin, Praulent, Repatha, etc):

_____

REFILLS: _____

(if not indicated prescription will expire one year from date signed)

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for

_____

Provider Name

Provider Signature _____ Date _____