

# 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, Praluent, 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