LEQVIO ORDERS

Please type or print. Complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Thank you for your referral and allowing us to partner with you in the care of your patient. Call 817-553-1325 with any questions.

Patient Name: _____DOB: _____

Phone: _____Allergies: _____

Weight: _____ ❑ lbs/❑ Kg Primary Diagnosis _____ICD-10: _____

Secondary Diagnosis_____ ICD-10:_____

Please obtain and fax results with your order to our infusion department at 817-553-1393:

- ❑ Patient Demographics including copies of insurance cards
- ❑ Last office visit notes including supporting documentation for ICD-10 codes and recent lipid panel (with in the last 90 days).

Prescription: (order valid for one year)

- ❑ **Initial dose**- LEQVIO (inclisiran) 284MG/1.5 ML subcutaneously initially, then repeat LEQVIO (inclisiran) 284MG/1.5ML subcutaneously in 3 months.
- ❑ **Maintenance dose**- LEQVIO (inclisiran) 284MG/1.5ML subcutaneously every 6 months.
- ❑ **Other**: LEQVIO (inclisiran) 284mg/1.5ML subcutaneously _____

Previous LEQVIO dose given on: ____/____/____

Ordering Provider Information

Name _____

Address _____

_____

NPI # _____

Signed _____

Office Contact Information

Name _____

Phone ( ) _____-_____

Fax ( ) _____-_____

Email _____

Date _____ /_____ /_____

Updated 11/11/24.