Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(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 _____

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