Leqvio

(Inclisiran sq injection)

NobleInfusion
Phone: 386-957-9600
Fax: 386-957-9400

PATIENT INFORMATION:

Patient Name: _____ ☐ Male ☐ Female
DOB: _____ Phone number: _____
Allergies: ☐ NKDA ☐ allergic to _____

Height: _____ Weight:_____

Fill in IDC-10 Code with diagnosis- Leqvio requires 2 IDC codes for authorization. Please provide 2.
1. _____code: _____
2. _____code: _____

REQUIRED TESTING/LABS

☐ pt insurance cards and demographics
☐ recent bloodwork
☐ last clinical note
☐ any diagnostic information relevant to the prescribing medication and dx

LEQVIO DOSING:

☐new start- 284 mg/1.5 mL SQ at day 0, month 3, then every 6 months thereafter

☐continuation of therapy- 284 mg/1.5 mL SQ
# of doses completed: _____.
Date of last dose:___/___/___

ORDERING PROVIDER:

Name: _____ NPI _____
Phone: _____ fax: _____
Practice Address: _____
City: _____ State: _____ Zip: _____

Provider Signature_____ Date: _____