Inclisiran (Leqvio)

Provider Order Form *rev. 10/12/2022*

IVX HEALTH

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

1st ICD-10 code (required): ICD-10 description:

2nd ICD-10 code: (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ **Inclisiran** (Leqvio)
- Dose: inclisiran sodium 284mg (pre-filled syringe)
- Route: subcutaneous injection
- Frequency: initial dose, again at 3 months, then every 6 months.

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Provider Name (Print) **Provider Signature** **Date**

Email LeqvioMed@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

FAX NUMBER FOR LEQVIO REFERRALS: (615) 628-1326