Inclisiran (Leqvio)

Provider Order Form rev. 1/19/2022

IVX HEALTH

PATIENT INFORMATION

Date:	Patient Name:		DOB:
ICD-10 code (required):		ICD 10-Description:	
☐ NKDA Allergies:			Weight lbs/kg:
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.
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 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