# Inclisiran (Leqvio)

***Provider Order Form*** *rev. 11/06/26*

arbor infusion

## PATIENT INFORMATION

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

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

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

## REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• **Reference:** Manufacturer Referral Checklist Form

## PRIMARY DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ E78.00 Pure hypercholesterolemia, unspecified
☐ E78.2 Mixed hyperlipidemia
☐ E78.011 Heterozygous familial hypercholesterolemia [HeFH]
☐ E78.4 Other hyperlipidemia
☐ E78.019 Familial hypercholesterolemia, unspecified
☐ E78.5 Hyperlipidemia, unspecified
☐ Other:

## SECONDARY DIAGNOSIS ICD-10 CODE *(Required)*

☐ I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris ☐ I10 Essential Hypertension
☐ Z95.820 Peripheral vascular angioplasty status with implants and grafts
☐ E11. Diabetes Mellitus ☐ N18. Chronic Kidney Disease
☐ Other:

## PRIMARY MEDICATION ORDER

Inclisiran (Leqvio) subcutaneous injection

• Refill for 12 months unless otherwise noted: _____

☐ ***New Start:*** 284mg subQ at Day 0, Month 3, and every 6 months thereafter

☐ ***Maintenance:*** 284mg subQ every 6 months

**SPECIAL INSTRUCTIONS**

## PRE-MEDICATION

**Note:** pre-meds not typically indicated for Leqvio

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV
☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
☐ Other: _____

Dose: _____ Route: _____

## NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

## APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

**Ordering Provider (Print)** **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

## PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

## ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772