

Inclisiran (Leqvio)

Provider Order Form rev. 8/23/26



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

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)

SPECIAL INSTRUCTIONS

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