INFUSE ONE
OHIO

Leqvio
(Inclisiran)

Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order:
Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; Recent Lipid Panel

PATIENT INFORMATION

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

Patient Name: Patient Phone: DOB:

ICD-10 code: (required) Primary Diagnosis: ☐ E78.00 ☐ E78.2 ☐ E78.49 ☐ E78.5 ☐ E78.011 ☐ E78.019 ICD Description:

AND Secondary Diagnosis:

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:

NURSING

☑ Center will use Hypersensitivity protocol established by Infuse One Ohio

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: ____________________

Dose: ________ Route: ________ Frequency: ________

SPECIAL INSTRUCTIONS:

THERAPY ADMINISTRATION

☑ Leqvio subcutaneous injection

☑ Dose: 284mg

Frequency (choose one):

☐ Initial dose, another dose at 3 months, then every 6 months

☐ Every 6 months (select if patient is continuing therapy)

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

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

Provider Name (Print) Provider Signature Date

☐ *Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.*