Premier Health
Miami Valley Hospital

PLACE LABEL HERE

Name: _____

Unit #: _____

Account #: _____

Infusion Center Inclisiran (Leqvio) Orders

Infusion Center Fax numbers:

MVH Middletown/AMC: 513-974-5023	MVH Troy/UVMC: 937-440-4503
MVH South: 937-641-2676	MVH Greenville: 937-641-7205
MVH North: 937-641-2378	

Patient Name: _____ **DOB:** _____

Patient Phone #: _____ **Patient Insurance:** _____

Required Labs and Documentation:

Current LDL-C Level: _____ Date taken: _____

Current LDL-C lowering treatments (s): _____

Check if applicable:

☐Patient was previously enrolled in an inclisiran clinical trial. Last inclisiran injection date: _____

1. Primary diagnosis (must select one; complete ICD-10 to highest level of specificity) – **REQUIRED**

I confirm the patient has been currently receiving statin therapy (or has been determined clinically intolerant) and has been diagnosed with:

☐**E78.** _____ **Hyperlipidemia** (E78.00, E78.2, E78.4, E78.49, E78.5)	**OR** ☐**E78.01 Familial hypercholesterolemia** ☐Z83.42 Family history of familial hypercholesterolemia ☐E75.5 Other lipid storage disorders ☐Other: _____ (supporting documents include Simon Broome diagnostic, Dutch Lipid Clinic score, and/or genetic testing)	**OR** ☐Other: _____ _____ _____ (specify ICD-10)

2. Secondary diagnosis (please complete if Hyperlipidemia above is selected; complete ICD-10 to highest level of specificity- RECOMMENDED

☐**Clinical ASCVD:**		**AND/OR**	☐Other clinical risk factors:
☐I2__. ____Ischemic heart disease	☐I70. ___Atherosclerosis	☐Other: _____	☐E11. ___Diabetes mellitus
☐I6__. ___cerebrovascular disease	☐I73. ___Other peripheral vascular disease	_____ (specify ICD-10)	☐I10. ___Hypertension ☐Other: _____

Inclisiran (Leqvio) Order (select all that apply) – Order valid for 1 year from provider signature date

Initial dose:	☐Inclisiran (Leqvio) 284mg/1.5mL subcutaneous initially, then 284mg/1.5mL subcutaneous in 3 months
Maintenance dose:	☐Inclisiran (Leqvio) 284mg/1.5mL subcutaneous every 6 months
Other:	☐Inclisiran (Leqvio) 284mg/1.5mL subcutaneous _____

***Previous dose given on: _____

Physician Signature: _____ **Date/Time:** _____

Printed Physician Name/Phone Number: _____

Orders complete by RN: _____ DATE/TIME: _____