McLeod Health

Place Sticker Here

Inclisiran (Leqvio) Treatment Plan

Patient Name: _____ DOB: _____

Weight (kg): _____ Allergies: _____

Diagnosis (select one ICD-10 code):

☐ E78.01 Heterozygous familial hypercholesterolemia

☐ Secondary prevention of cardiovascular events

☐ Other ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

- Inclisiran (Leqvio) 284mg/1.5mL prefilled syringe administered subcutaneously into the abdomen, upper arm, or thigh

Dose: ☐ 284mg as a single injection

Frequency

Induction: Week 0 and 12 then every 6 months thereafter

Maintenance: Every 6 months

Other: _____

Order Duration:

1 year unless otherwise specified (Other: _____)

Lab Orders:

☐ Lipid profile (fasting or non-fasting) to establish baseline

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

If your office is not on Epic, please fax completed Treatment Plan with authorization information to McLeod Infusion Services at the preferred location or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-6195 (Phone)