



Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

LEQVIO MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ Diagnosis A diagnosis from **each** of the two columns is required, both a primary **and** secondary diagnosis.

- | | |
|---|---|
| <input type="checkbox"/> E78.00 Pure hypercholesterolemia, unspecified | <input type="checkbox"/> I25.10 ASCVD nativa CA w/o angina pectoris |
| <input type="checkbox"/> E78.01 Familial hypercholesterolemia | <input type="checkbox"/> I25.110 ASCVD nativa CA w/angina pectoris |
| <input type="checkbox"/> E78.2 Mixed hyperlipidemia | <input type="checkbox"/> I25.110 ASCVD native CA w/angina w/spasm |
| <input type="checkbox"/> E78.41 Elevated lipoprotein(s) | <input type="checkbox"/> I23.7 Postinfarction angina |
| <input type="checkbox"/> E78.49 Other hyperlipidemia, familial combined | <input type="checkbox"/> I25.84 Coronary athero. due to lipid rich plaque |
| <input type="checkbox"/> E78.5 Hyperlipidemia, unspecified | <input type="checkbox"/> _____ |

■ Details Needed for Approval Please answer all questions and provide supporting documentation.

- What approved condition (above) is this medication being used to treat? ASCVD HeFH Other: _____
- Circle all of the following which apply to the patient:
For Dx ASCVD: Prior MI Hx of acute coronary syndrome Angina Hx of stroke or TIA Atherosclerotic PAD CABG Stent
 Angioplasty Percutaneous coronary intervention ≥50% stenosis on CT or angiography
For Dx HeFH: Tendon xanthoma (self or primary relative) Fam Hx of total cholesterol ≥190 Fam Hx MI 1st degree relative ≤ 60y/o
 Fam Hx MI 2nd degree relative ≤ 50y/o CAC score ≥100 Dutch Lipid Score greater than 5
- Was patient's LDL equal to or greater than 190 mg/dL prior to antihyperlipidemic agents? _____
- Was patient on max statin at least 3 mo? _____ Will they continue on them concurrently? _____ When was it started? ____/____/____
- Was the patient on Ezetimibe for at least 3 months? _____ Did they fail on it? _____ Are there Ezetimibe contraindications? _____
- Was the patient on a PCSK9 inhibitor for at least 3 months? _____ If yes, which one? _____
 Did they fail on a PCSK9 inhibitor? _____ Are there any PCSK9 inhibitor contraindications? _____
- Does patient have statin intolerance? _____ Is statin therapy contraindicated? _____ Specify intolerance: _____
- If the diagnosis is HeFH, include genetic testing and criteria scores (ie. Dutch Lipid, Simon Broome, etc).
- Will the patient be on a diet while using Leqvio? _____ Will they be taking a PCSK9 inhibitor concurrently while using Leqvio? _____
- Recent comprehensive lipid panel, documentation of patient's statin history or history of intolerance, and all supporting documents.

■ Medication Order

- Initial phase of Leqvio (inclisiran) 284mg SubQ injection at months 0 and 3. (If maintenance also ordered, 1st dose is 6 months after initial phase.)
- Maintenance phase of 284mg SubbQ injection every 6 months for 1 year.

Choose an injection site per the manufacturer's instructions, inject the full amount in the syringe, and discard in a sharps box.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.