# MHS Home/Alternate Site Infusion Services
# Inclisiran (Leqvio) Injection Order Set

**ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER**

| **Patient Name:** | **DOB:** _____/_____/_____ | **Weight:** __________ lb/kg |
|---|---|---|
| **Patient Phone Number:** (______) ______-________ | **Requested Date of Service:** _____/_____/_____ | |
| **Patient Allergies:** | | |

**Diagnosis:** ________________________________________________________ **ICD – 10 Code:** ____________________________

**Baseline labs required:**
Lipid profile (fasting or non-fasting) Date: _____/_____/_____ Result: _______________

**Maintenance labs required:**
Lipid profile (fasting or non-fasting) 4-12 weeks after starting therapy
Lipid profile (fasting or non-fasting) every 3-12 months

**Additional Requirements:** In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider ________________________ (required) ****

## Provider Order for Inclisiran (Leqvio) Injection

| ORDERS WITH CHECK BOXES | When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated. |
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**Medication:**
Inclisiran (Leqvio) 284 mg SUBQ x 1. Repeat dose in 3 months (12 weeks), then continue every 6 months (24 weeks)

**Skilled Nurse to draw labs as follows:**
- ☐ Lipid profile (fasting or non-fasting) 4-12 weeks after starting therapy
- ☐ Lipid profile (fasting or non-fasting) Frequency: ______________________________________
- ☐ Other Lab(s): ________________________________________ Frequency: ______________________________________

**Skilled Nurse Interventions:**
- Admit *(first visit)* patient to services for home/alternate site injection therapy of Inclisiran (Leqvio).
- Complete Skilled Nurse visit with each injection for ongoing home/alternate site injection therapy of Inclisiran (Leqvio).
- Obtain vital signs (TPR & B/P) at baseline and at completion of injection.
- Obtain patient weight at each visit.
- Inject Inclisiran (Leqvio) as ordered.
- If vital signs are stable after injection and any observation period, Skilled Nurse will complete visit.

**If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.)**:
The Skilled Nurse will:
- Administer emergency medications as prescribed (*below*).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

**CONTINUED ON NEXT PAGE**

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

| **Patient Identification:**<br>Name:<br>MRN:<br>DOB: | Pre-printed order – Page 1 of 2<br>Inclisiran (Leqvio)<br>MultiCare |
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**Emergency Medications**: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

**Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.**

**Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)**

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

**Provider Signature:** ______________________________ **Printed Name:** ______________________________ **Date:** ____________

**NPI:** ________________________ Orders expire in 12 months unless otherwise specified: ______________________________

| **Provider/Clinic Information:**<br>Address: ____________________________________<br>Phone #: ________________ Fax#: ________________ | **Return completed orders to:**<br>MultiCare Home/Alternate Infusion Services<br>253-459-6650 *(phone)* / 253-864-2785 *(fax)* |
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FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

| **Patient Identification:**<br>Name:<br>MRN:<br>DOB: | Pre-printed order – Page 2 of 2<br>Inclisiran (Leqvio)<br>MultiCare Revised 06/24 |
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