ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Inclisiran (Leqvio)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:

- ❑ Heterozygous familial hypercholesterolemia — **ICD -10 Code:** ❑ _____
- ❑ Secondary prevention of cardiovascular events — ❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

- Lipid profile (fasting or non-fasting)

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

Treatment Regimen:

Inclisiran (Leqvio) given SUBQ

❑ 284 mg SUBQ x1; repeat dose in 3 months (12 weeks) and continue every 6 months (24 weeks)

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contract provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4C)

If hypersensitivity develops (fever, chills, hyptension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

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)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Order expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

HYPEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA

MultiCare

60-0197-3 (Rev. 9/24)