ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

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

ICD -10 Code:

Diagnosis:
❑ Heterozygous familial hypercholesterolemia ❑_____
❑ 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.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further 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
HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA

MultiCare

60-0197-3 (1/23)