Oregon Specialty Infusion
A Practice of Oregon Specialty Group

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐ M ☐ F	NPI:_____
Height:_____ Weight:_____ lbs.	Practice:_____
Allergies:_____	Phone:_____
Diagnosis:_____	Fax:_____
ICD-10 Code(s):_____	Contact Name:_____

Has the patient been treated for this condition previously? ☐ No ☐ Yes, medication(s):_____

Is the patient currently on therapy? ☐ No ☐ Yes, medication(s):_____

☐ **LEQVIO (inclisiran)**

- ☐ New Start Dosing: 284 mg Leqvio by Sub Q once, then in 3 months.
- ☐ Maintenance Dosing: 284 mg Leqvio by Sub Q every 6 months.

Quick Checklist for New and Returning Leqvio Patients.

- ☐ Include Demographic Sheet and Copy of Insurance Card(s).
- ☐ Completed Oregon Specialty Infusion Order Form/Signed RX
- ☐ Recent Office Visit Note (Including Statin History)
- ☐ Recent LDL
- ☐ Any Additional Pertinent Information to Support Insurance Prior Authorization.

Physician's Signature:_____ **Date:**_____