



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex:  M  F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  lbs  kg  
 Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_

**<ICD 10 CODE REQUIRED>**

**DIAGNOSIS & CLINICAL INFORMATION**

**ICD 10 Code (PROVIDE COMPLETE CODE)**

- |  |   |
|--|---|
| <input type="checkbox"/> E78.2 Mixed Hyperlipidemia        | <input type="checkbox"/> E78.9 Disorder of Lipoprotein Metabolism |
| <input type="checkbox"/> E78.41 Elevated Lipoprotein       | <input type="checkbox"/> E78.01 Familial Hypercholesterolemia     |
| <input type="checkbox"/> E78.49 Other Hyperlipidemia       | <input type="checkbox"/> I25.10 Atherosclerotic Heart Disease     |
| <input type="checkbox"/> E78.5 Hyperlipidemia, unspecified | <input type="checkbox"/> Other: _____                             |

**REQUIRED:** Demographics & Most Recent: H&P, clinical notes, imaging, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

**LAB RESULTS:** Include LDL cholesterol blood level

**PRESCRIPTION**

**Pre-Medications**

- |   |  |
|---|--|
| <input type="checkbox"/> Acetaminophen: 650 mg PO   | <input type="checkbox"/> Acetaminophen: _____ mg PO      |
| <input type="checkbox"/> Cetirizine 10 mg PO        | <input type="checkbox"/> Famotidine: _____ mg IV         |
| <input type="checkbox"/> Dexamethasone: _____ mg IV | <input type="checkbox"/> Loratadine 10 mg PO             |
| <input type="checkbox"/> Diphenhydramine: 25 mg PO  | <input type="checkbox"/> Methylprednisolone: _____ mg IV |
| <input type="checkbox"/> Diphenhydramine: 25 mg IV  | <input type="checkbox"/> Ondansetron 4 mg IV             |
| <input type="checkbox"/> Other: _____               |  |

**Lab Orders**

- CBC w/diff: every \_\_\_\_\_  weeks  month  
 CMP: every \_\_\_\_\_  weeks  month  
 Other: \_\_\_\_\_  weeks  month

**Leqvio (inclisiran)**

**Loading Dose (Select One)**

- SQ:** inject 284 mg subcutaneously initially, again at 3 months, and then every 6 months from injection at month 3.

**Maintenance Dose (Select One)**

- SQ:** inject 284 mg subcutaneously once every 6 months

Is the patient on any other disease modifying therapy?  Yes  No  
 If yes, please note therapy and last dose: \_\_\_\_\_

**Adverse Events:** In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

**PRESCRIBING INFORMATION**

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Office phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_