LEQVIO® (inclisiran) injection 284 mg/1.5 mL

Horizon Infusions

Location
- ☐ Camillus
- ☐ Liverpool
- ☐ New Hartford

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305
Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: ☐ M ☐ F	Weight: ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable)*:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:		State Zip
Office Contact:		Email:
Office phone:		Office fax:

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

- ☐ Heterozygous Familial Hypercholesterolema (HeFH) (_____)
- ☐ Atherosclerotic Cardiovascular Disease (ASCVD) (_____)
- ☐ Other _____
- ☐ Lipid Panel Annually

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

LEQVIO

- ☐ Administer 284mg SubQ initially, again at 3 months, then Q6 months
- ☐ Maintenance dose Q6 months
- ☐ Vital signs per HI Protocol
- ☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
- ☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other _____

POST-MEDICATIONS ☐ N/A

- ☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

6. LABS

☐ CBC w/Diff	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____

- ☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
- ☐ Other (*specify*):_____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____ DATE _____