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**Leqvio® Order Form**  
Epic Referral: REF115173

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**ICD-10 Diagnosis Code:** \_\_\_\_\_

**Rx:**

**Induction (Only check if patient is a new start):**

Inclisiran (Leqvio) 284 mg subcutaneous injection at months 0, 3, and then every 6 months thereafter.

**Maintenance:**

Inclisiran (Leqvio) 284 mg subcutaneous injection every 6 months.

**Order duration:**

1 year     6 months     Other duration: \_\_\_\_\_

**Please send lipid panel results with order. We must have these on file within the past 6 months prior to initiating treatment. If no results available, fasting lipid panel will be drawn onsite prior to initial dose (patient must be scheduled for appointment in the morning).**

Other Comments:  
\_\_\_\_\_

**Prescriber Printed Name:** \_\_\_\_\_

**Prescriber Full Address:** \_\_\_\_\_

**Office Phone Number:** \_\_\_\_\_ **Office Fax Number:** \_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_