Provider Order Form

LEQVIO (INCLISIRAN)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Atherosclerotic Heart Disease I25. _____ ☐ Familial Hypercholesterolemia Z83.42 ☐ Hyperlipidemia E73. _____

☐ Other _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Leqvio (Inclisiran), Subcutaneous Injection	☒ 284 mg	☐ Induction: Month 0, 3, then repeat every 6 months ☐ Maintenance: Every 6 months

Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance Card ☐ Progress Notes Supporting DX

_____ _____

Provider Signature Date