Ascension Rx

Inclisiran (Leqvio & Biosimilar) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☐ Lipid Panel
  - ☑ Maintenance (every _____)
    - ☐ Lipid Panel
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

If a planned dose is missed by more than 3 months, restart with a new dosing schedule - administer Inclisiran initially, again at 3 months, and then every 6 months.

Nursing Order

- ☑ Notify the provider if a planned dose is missed by more than 3 months.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg IV once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____

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Medication Orders

Initial Treatment:

☐ Inclisiran 284 mg SQ once initially and again at 3 months

Maintenance Treatment only:

☐ Inclisiran 284 mg SQ once every 6 months

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

☐ Payer-mandated substitution
☐ Financial stewardship
☐ Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Inject LEQVIO subcutaneously into the abdomen, upper arm, or thigh. Do not inject in areas of active skin disease or injury, such as sunburns, skin rashes, inflammation, or skin infections.

Emergency / Hypersensitivity Orders

☑ Notify provider for next steps once patient stabilized
☑ Follow standard orders for management of allergies and anaphylaxis reactions
☑ In absence of standard protocol, follow the orders below:
- ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
- ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
- ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
- ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
- ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
- ☑ Famotidine 20 mg IV Once PRN hives/itching
- ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
- ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

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Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated