TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

Return Completed Form To:
888.898.9113

INFUSION ORDER – LEQVIO® (inclisiran)

Patient First Name: _____ Patient Last Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____
Referral Date: _____ Weight (kg): _____ Height (in): _____
Allergies: _____

Diagnosis:

☐ E78.01: Familial Hypercholesterolemia ☐ Z83.42: Family History of Familial Hypercholesterolemia

☐ I25.10 Atherosclerotic Heart Disease of native coronary artery without angina pectoris

☐ Other ICD-10 Diagnosis Description:

Pre-screening:

☐ Baseline Lipid Panel

Dose: LEQVIO® (inclisiran)

☐ Induction: Administer 284mg/1.5ml sub-cutaneous injection into the abdomen, upper arm or thigh at day 0, month 3 and then every 6 months

☐ Maintenance: Administer 284mg/1.5ml sub-cutaneous injection into the abdomen, upper arm or thigh every 6 months

Special Orders:

Prescribing Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.