

 NEW ENGLAND
Cancer Specialists

Infusion Center

Kennebunk • Portsmouth • Scarborough • Topsham

Phone: 207-303-3225 Fax: 207-692-2473

Leqvio (Inclisiran) Order Form

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____

Height: _____ (cm) Actual Weight: _____ (kg) Allergies: _____

Leqvio (Inclisiran):

Indication: Heterozygous Familial Hypercholesterolemia

Secondary Prevention of Cardiovascular Events

FDA approved Dose:

284 mg SubQ as a single injection initially, again at 3 months, and then every 6 months thereafter.

(please check all that apply):

284 mg subcutaneously as initial injection

284 mg subcutaneously at 3 months

284 mg subcutaneously every 6 months

Orders valid through ____ / ____ / ____

*In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____