McLeod Health

Inclisiran (Leqvio) Treatment Plan

Patient Name: _____ DOB: _____

Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one ICD-10 code):

☐ E78.01 Heterozygous familial hypercholesterolemia

☐ Secondary prevention of cardiovascular events

☐ Other ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

- Inclisiran (Leqvio) 284mg/1.5mL prefilled syringe administered subcutaneously into the abdomen, upper arm, or thigh

Frequency

☐ Induction: Week 0 and 12 then every 6 months thereafter

☐ Maintenance: Every 6 months

☐ Other: _____

Order Duration: 1 year unless otherwise specified (Other: _____)

Lab Orders:

☐ Lipid profile (fasting or non-fasting) to establish baseline

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received inclisiran at another facility, please provide last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.