

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ Ph: _____

Medical Assessment

Diagnosis (ICD-10): _____

<u>Leqvio (Inclisiran)</u> ☐ E78.00- Pure hypercholesterolemia, unspecified ☐ E78.2- Mixed hyperlipidemia ☐ E78.49- Other hyperlipidemia ☐ E78.5- Hyperlipidemia, unspecified ☐ E78.011- Heterozygous familial hypercholesterolemia ☐ E78.019- Familial hypercholesterolemia, unspecified	<u>Amvuttra (Vutisiran)</u> ☐ E85.1- Neuropathic hereditary amyloidosis ☐ E85.82- Wild-type transthyretin-related (ATTR) amyloidosis ☐ E85.4- Organ-limited amyloidosis	<u>Evkeeza (Evinacumab)</u> ☐ E78.010- Homozygous familial hypercholesterolemia (HoFH)	<u>Onpattro (Patisiran)</u> ☐ E85.1- Neuropathic hereditary amyloidosis
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Failed Statin therapies: _____

Failed Other Medications: _____

 Is this the first dose? ☐ yes ☐ no If no, date first dose given: _____

Please include a demographics page, front and back of an insurance card, any clinical notes with supporting diagnosis, lab-work—lipid panel, tests, and any other supporting documentation including past tried and / or failed therapies associated with diagnosis.*

Pre-Medication Orders:

- | | |
|---|---|
| ☐ APAP ☐ 325mg ☐ 500mg ☐ 650mg - PO 30 minutes before infusion
☐ Alternate Oral Antihistamines: ☐ Cetirizine 10mg ☐ Loratadine 10mg ☐ Fexofenadine 60mg or ☐ 180mg
☐ Famotidine ☐ 20mg PO ☐ 40mg PO ☐ 20mg IVP ☐ 40mg IVP | ☐ Diphenhydramine ☐ 25mg ☐ 50mg – PO 30 min before infusion
OR ☐ 25mg IVP ☐ 50mg IVP
☐ Methylprednisolone ☐ 40mg IVP ☐ 125mg IVP or other _____ mg IVP
☐ Ondansetron ☐ 4 mg IVP ☐ 4 mg PO |
|---|---|

Labwork: _____ To be Drawn by: ☐ Infusion Clinic ☐ Referring Provider

Allergies: _____

Medication
Amvuttra (Vutisiran)

- ☐
- 25 mg SC every 3 months
-
- ☐
- Refills: _____

Leqvio (Inclisiran)

- ☐
- Induction: 284 mg day 0 and month 3
-
- ☐
- Maintenance: 284mg at month 9 and every 6 months
-
- ☐
- Refills: _____

Evkeeza (Evinacumab) (weight based)

- ☐
- 15mg/kg _____ mg IV every 4 weeks
-
- ☐
- Refills: _____

Onpattro (Patisiran) (weight based)

- ☐
- <100 kg: 0.3 mg/kg _____ mg IV every 3 weeks
-
- ☐
- 100 kg or greater: 30 mg IV every 3 weeks
-
- ☐
- Refills: _____

Physician Prescription Orders

Address: _____ Phone: _____

Fax: _____ Clinic Contact: _____ Physician Name: _____

NPI # _____ Physician Signature: _____ Date: _____