Hematology-Oncology Associates of CNY

Conveniently Located in East Syracuse, Camillus & Auburn

Main Office Phone 315-472-7504

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Leqvio (Inclisiran) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ **Height (inches):** _____ **Weight (lbs):** _____

3. Diagnosis:

[ ] I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
[ ] I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
[ ] 125.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
[ ] I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
[ ] I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
[ ] I25.700 Atherosclerosis of coronary artery bypass graft9s0s, unspecified, w/ unstable angina pectoris
[ ] 125.701 Atherosclerosis of coronary artery bypass graft9s0, unspecified, w/ angina pectoris w/ spasm
[ ] E78.49 Other hyperlipidemia, familial combined hyperlipidemia
[ ] E78.9 disorder of lipoprotein metabolism, unspecified
[ ] E78.00 Pure hypercholesterolemia, unspecified
[ ] E78.01 Familial hypercholesterolemia
[ ] E78.2 Mixed hyperlipidemia
[ ] E 78.5 Hyperlipidemia, unspecified
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, referring office will be notified and HOACNY will not be able to administer the medication.

4. Pre-medications:

[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

5. Drug Order: Leqvio (Inclisiran) *Ok to substitute for generic/biosimilar*

Dose/Frequency:

[ ] **Induction: 284mg/1.5ml Subcutaneous injection at day 0 & month 3**
[ ] **Maintenance: 284mg/1.5ml Subcutaneous injection every 6 months after month 3**

[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] Fasting lipid profile every _____ (4-12) weeks following initiation of therapy
[ ] No lab monitoring indicated to proceed

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing Completed**:

[ ] Lipid Profile (fasting or non-fasting), Date: _____
[ ] Patient has trialed & failed the following therapies (include drug/dates): _____
[ ] Patient has intolerance to the following therapies): _____

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

Physician's Name: _____ **Phone:** _____
Physician's Signature: _____**Date:** _____

(This drug administration order form is valid for 12 months)