

Leqvio® (inclisiran) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Last Treatment Date:	Weight (lbs/kg): Height:
ICD-10 Code (required):	ICD-10 Description:	Secondary ICD-10: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:
Physician Preferred Method of Contact:	Email: Fax: Phone:

STANDING ORDERS

☒ Infusion to be administered per Vivo protocols.

LEQVIO ADMINISTRATION

Initial /Reload Dosing: 284 mg subcutaneous Injection
*Frequency: initial dose, again at 3 months, then every 6 months
Maintenance Dosing: 284 mg subcutaneous Injection every 6 months

REQUIRED DOCUMENTATION

PREMEDICATIONS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25mg 50mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Cholesterol with LDL

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print)

Provider Signature

Date

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

Order is valid for one year unless otherwise noted.

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