

Columbus Community Hospital

Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here

**PHYSICIANS ORDERS
(including Medications)**

Inclisiran (LEQVIO) Injection

(8/2024)

Page 1 of 2

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

This plan will expire after 365 days at which time a new order will need to be placed

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P** or **most recent chart note**.
2. When clinically indicated, LDL-lowering effect may be measured as early as 30 days after initiation and anytime thereafter without regard to timing of the dose.
3. Add **LEQVIO** Patient Authorization and & Additional Consents as applicable.

MEDICATIONS:

- **inclisiran (LEQVIO) 284 mg**, subcutaneous, ONCE. Administer injection into the abdomen, upper arm, or thigh. Do not inject in areas of active skin disease or injury (e.g., sunburns, skin rashes, inflammation, skin infections).
Interval: (must check one)
 Once every 3 months x 2 doses, then every 6 months thereafter
 Every 6 months
 Other: _____

HYPERSENSITIVITY:

1. **NURSING COMMUNICATION** – If hypersensitivity reactions develop, refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Continue to assess as grade of severity may progress.
5. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen, 975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

(cont.)



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My NPI number is _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ Date/Time: _____

Printed Name: _____ Phone: _____ Fax: _____

