RELIANT SPECIALTY INFUSION

AIC Cardiology Fax: 833-808-0833

Patient Information

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

Medical Assessment

Diagnosis (ICD-10):

Leqvio (Inclisiran)	**Amvuttra (Vutrisiran)**	**Evkeeza (Evinacumab)**	**Onpattro (Patisiran)**
☐ 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	☐ E85.1- Neuropathic heredofamilial amyloidosis ☐ E85.82- Wild-type transthyretin-related (ATTR) amyloidosis ☐ E85.4- Organ-limited amyloidosis	☐ E78.010- Homozygous familial hypercholesterolemia (HoFH)	☐ E85.1- Neuropathic heredofamilial amyloidosis

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:*** _____