Lake Charles Memorial Health System

1PO

PO_OUTPATIENT LEQVIO ORDERS
Last Revised: 08/04/2025

OUTPATIENT INCLISIRAN (LEQVIO) ORDERS:

Name: _____ DOB _____ Allergies: _____

Height: _____ Weight: _____kg

Assign as Outpatient

Diagnosis: consider inclisiran for patients who do not meet cholesterol treatment goals with dietary modification and other lipid-lowering therapies (ex: maximally tolerated statin plus ezetimibe and/or a PCSK9 inhibitor)

Primary diagnosis – selection of one is required

____E78.00 Pure hypercholesterolemia, unspecified
____E78.01 Familial hypercholesterolemia
____E78.2 Mixed hyperlipidemia
____E 78.49 Other hyperlipidemia, familial combined hyperlipidemia
____E78.9 Disorder of lipoprotein metabolism, unspecified
____Other ICD-10 Code and description:_____

Secondary diagnosis - recommended

____Atherosclerotic heart disease (ASCVD)
_____I25.10 ASCVD of native coronary artery w/o angina pectoris
_____I25.110 ASCVD of native coronary artery w/ unstable angina pectoris
_____I25.111 ASCVD of native coronary artery w/angina pectoris and documented spasm
_____I25.118 ASCVD of native coronary artery with other forms of angina pectoris
_____I25.119 ASCVD of native coronary artery with unspecified angina pectoris
_____I25.700 ASCVD of coronary artery bypass graft, unspecified w/angina pectoris
_____I25.701 ASCVD of coronary artery bypass graft, unspecified w/angina pectoris and spasm

Labs/Physician Reminder: labs to be completed prior to arrival at infusion center

1. Comprehensive lipid panel/LDL-C prior to initial dose (if not done within the last 90 days)
2. Fasting lipid profile should be rechecked 4-12 weeks after starting therapy and every 3-12 months thereafter. LDL-C may be checked as early as 30 days after initiation and anytime thereafter without regard to timing of the dose
3. If a dose is missed by greater than 3 months, skip the missed dose and restart with a new dosing schedule as initial dose, then again at 3 months and then every 6 months

Nursing:

1. Assess outpatient labs and report abnormalities to physician.
2. If emergency medications are needed once therapy initiated, STOP therapy, initiate emergency PRN medications and contact physician. May initiate oxygen therapy for emergency management via nasal cannula at 2 liters per minute. Keep O2 Sat above 95%

Medications:

1. Inclisiran (Leqvio) dosing (SQ into abdomen, upper arm or thigh)
   ____*First dose*: 284mg SQ x1
   ____*Second dose*: 284mg SQ x1 - 3 months after 1st dose
   ____*Subsequent maintenance doses:* starting 6 months after 2nd dose, 284mg SQ every 6 months

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Previous Leqvio dose given on: ____/____/_____

2. Emergency medications:
   a) acetaminophen 650mg PO once as needed for temperature > 101
   b) diphenhydrAMINE injection 25mg IVP once as needed for itching, facial flushing, hives, rash, SBP less than 90 mm Hg, wheezing, shortness of breath, or facial/lip tongue swelling. May repeat x 1 for a total of 50mg. Max dose for undiluted IV administration = 50mg given over 1 minute.
   c) MethylPREDNISolone sodium succinate 125mg injection IVP once as needed for SBP less than 90 mm Hg, wheezing, shortness of breath, facial/lip/tongue swelling, itching, facial flushing, hives or rash unrelieved with diphenhydramine. May repeat x 1 for a total of 250mg.
   d) EPINEphrine 0.3mg IM every 5 minutes as needed for anaphylaxis, SBP less than 90 mm Hg, wheezing, shortness of breath, or facial/lip/tongue swelling not relieved with diphenhydrAMINE and methylPREDNISOLONE. May repeat x 1 dose for a total of 0.6mg
   e) Ondansetron 8mg IV once as needed for nausea or vomiting or infusion reaction
   f) _____Promethazine 25mg tablet PO once as needed for nausea, vomiting or infusion reactions if ondansetron not ordered or ondansetron ineffective
   g) Famotidine 20mg injection IVP once as needed for anaphylaxis reaction in addition to diphenhydramine and methylprednisolone
   h) Sodium chloride 0.9% 500ml once as needed for SBP less than 90 mm Hg or suspected anaphylaxis in conjunction with all other medications used for hypotension or anaphylaxis

Discharge when treatment complete
New MD order required every 12 months

Physician Signature: _____ Date/Time:_____