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Seaford, DE 19973
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1324 Belmont Avenue; Unit 105
Salisbury, MD 21804
Phone: 443.944.8031/Fax: 443.944.9379

Cardiology Infusion Order

Patient name _____ DOB _____

Phone number _____

Please make sure required test are current (within 90 days). Must include statin history and/or additional lipid lowering treatments tried previously.

Hypercholesterolemia (E78.00)

Lipid Panel (Required)

_____ Leqvio

Initial dose _____ 284 mg/1.5ml subcutaneous initially, then 284 mg/1.5ml subcutaneous in 3 months

Maintenance dose _____ 284 mg/1.5ml subcutaneous every 6 months

_____ Other or additional instructions _____

Is this a new treatment for this patient _____ or continuing treatment _____

If continuing treatment date of last Leqvio _____

Prior tried and failed medications _____

Contact person _____ Phone _____ Fax _____

Name of ordering provider _____

Ordering provider signature _____ Date _____

Order valid for one year.

Please fax this information, required tests, last two office notes, and insurance cards to infusion coordinator at 302-613-4697. Infusion coordinator can be reached at 302-483-7053.

Additional forms may be found on our website at ArthritisDE.com.