RELIANT SPECIALTY INFUSION

AIC Cardiology **Fax: 833-808-0833**

Patient Information

Patient Name: _____ DOB: _____ Height: _____ Weight: _____
Patient Contact #: _____

Medical Assessment

Diagnosis (ICD-10):

- ❑ E78.01 – Familial Hypercholesterolemia
- ❑ Z83.42 – Family History of Familial Hypercholesterolemia
- ❑ I25.10 – Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris
- ❑ E75.8 – Primary Hyperlipidemia
- ❑ Other: _____

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.
- ❑ Diphenhydramine □ 25mg □ 50mg – PO 30 minutes before infusion.
  □ 25mg IVP □ 50mg IVP
- ❑ Alternate Oral Antihistamines: □ Cetirizine 10mg □ Loratadine 10mg □ Fexofenadine 60mg or □180mg
- ❑ Methylprednisolone □ 40mg IVP □ 125mg IVP or other ____ mg IVP
- ❑ Famotidine □ 20mg PO □ 40mg PO □ 20mg IVP □ 40mg IVP
- ❑ Ondansetron □ 4 mg IVP □ 4 mg PO

Labwork: _____ To be Drawn by: □ Infusion Clinic □ Referring Provider

Allergies: _____

Medication

Amvuttra *(Vutisiran)*

- ❑ Inject 25 mg SC every 3 months
- ❑ **Refills**: _____

Leqvio *(Inclisiran)*

- ❑ **Induction**: Administer 284 mg / 1.5ml at day 0, month 3, and then every 6 months.
- ❑ **Maintenance**: Administer 284mg / 1.5ml every 6 months
- ❑ **Refills: _____**

Onpattro (Patisiran)

- ❑ **Less than 100 kg**: 0.3 mg/kg IV every 3 weeks by IV infusion
- ❑ **Equal to or Greater than 100 kg**: 30 mg IV every 3 weeks
- ❑ **Refills: _____**

Physician Prescription Orders

Address: _____ Phone: _____
Fax: _____ Clinic Contact: _____Physician Name: _____
NPI #_____Physician Signature: _____***Date:*** _____