



INFUSION SUITE		LEQVIO INJECTION ORDERS	
Durango Infusion Center 270 E 8th Ave Ste N101 Durango, CO 81301		Phone: 970-828-3500	Fax: 970-828-3501
PATIENT INFORMATION - Include Patient Demographics and Insurance Cards			
Name:		DOB:	
MEDICAL INFORMATION			
ICD10:		Patient Height:	
Patient Weight (kg):		Allergies:	
*Weigh patient prior to each infusion			
REQUIRED TESTING			
<input type="checkbox"/> Lipid Panel: _____			
Additional labs: _____			
PREMEDICATIONS 30 minutes prior to starting			
<input type="checkbox"/> Acetaminophen:	<input type="checkbox"/> 325mg PO X1	<input type="checkbox"/> 500mg PO X1	<input type="checkbox"/> 650mg PO X1 <input type="checkbox"/> 1000mg PO X1
<input type="checkbox"/> Diphenhydramine:	<input type="checkbox"/> 25mg IV X1	<input type="checkbox"/> 25mg PO X1	<input type="checkbox"/> 50mg IV X1 <input type="checkbox"/> 50mg PO X1
<input type="checkbox"/> Solumedrol:	<input type="checkbox"/> 40mg IV X1	<input type="checkbox"/> 100mg IV X1	<input type="checkbox"/> 125mg IV X1
<input type="checkbox"/> Antihistamine:	<input type="checkbox"/> Cetirizine 10mg PO X1 <input type="checkbox"/> Loratadine 10mg PO X1		
<input type="checkbox"/> Additional PRN:			
LEQVIO ORDERS			
<input type="checkbox"/> Initial:	284mg subcutaneous day 1, month 3, then every 6 months		
<input type="checkbox"/> Subsequent:	284mg subcutaneous every 6 months X 2		
POST INJECTION			
<input type="checkbox"/> Discharge home			
Referring Provider Printed:		NPI:	
Referring Provider Signature:		Date:	
Referring Provider Phone:		Referring Provider Fax:	
DNG Provider Printed:			
DNG Provider Signature:		Date:	

*\*Credentials must be included*

**Injection Directions:**

- Remove pre-filled syringes and allow to sit at room temperature for at least 30 minutes
- Inject in the thigh, abdomen (greater than 2" around navel), or outer area of upper arm