

LEQVIO Order Form

Fax completed form to: _____



PATIENT INFORMATION			
Patient Name:		Date of Birth:	Referral Date:
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	DEA #:
Practice Name:		NPI#:	
Address:		City/State/Zip:	
Office Contact:	Phone:	Fax:	
Supervisory Physician (if applicable):			
DIAGNOSIS			
ICD 10 Code Required		Other: _____ ICD 10: _____	
Atherosclerotic heart disease (ASVD), ICD 10: I25.10			
Familial Hypercholesterolemia (HeFH), ICD 10: E78.01			
PLEASE ATTACH			
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Baseline blood level of LDL within the past 3 months Current medication list & list of prior medications tried and failed (with dates) Letter of medical necessity if drug dosing or indication is outside of FDA guidelines		Patient currently on maximally tolerated statin therapy OR patient is not currently on statin therapy and has documented intolerance or contraindication to statin therapy. Current statin therapy: Drug name: _____ Dosage: _____ Start date or length of therapy: _____ Patient is on Zetia® (ezetimibe) in addition to statin therapy Patient is statin intolerant Patient has a contraindication for statin therapy: _____ Patient has been compliant with lipid lowering drug therapy and lifestyle modifications.	
For ASCVD: History of clinical atherosclerotic cardiovascular disease includes one or more of the following: ASCVD score Acute coronary syndrome Coronary artery disease (CAD) History of myocardial infarction (MI) Stable or unstable angina		For HeFH: Confirmed by Simon Broome Register Diagnostic Criteria: _____ Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein (LDLRAP1) gene WHO/Dutch Lipid Clinic Network Score (DLCNS) > 8 points, Score: _____ Other: _____	
Coronary or other arterial revascularization Stroke Transient ischemic attack (TIA) Peripheral arterial disease (PAD) Other: _____			
NURSING & LAB ORDERS			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
Lab Orders:		Lab Date & Frequency:	
PRESCRIPTION ORDERS			
Anaphylaxis Kit:	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 40-60mg via IM injection as needed
(Check all that apply)	Diphenhydramine _____ mg PO as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other
Supply Orders: All supplies as appropriate to therapy will be provided as necessary.			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose?	Yes	No	If No, when was last dose given? _____ When is patient due for next dose? _____
LEQVIO	Induction: 284mg SC injection at month 0 and 3 Maintenance: 284mg SC injection every 6 months		NONE
OTHER			_____
By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.			

Prescriber's Signature _____
 Dispense as Written _____

Print Name _____
 Date _____

Prescriber's Signature _____
 Substitution Permitted _____

Print Name _____
 Date _____

