# LEQVIO® Referral Form

**Fax completed form to: 833-908-1122**

amerita
specialty infusion services

## 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**

☐ Atherosclerotic heart disease (ASVD), IC 10: I25.10
☐ Familial Hypercholesterolemia (HeFH), ICD 10: E78.01
☐ Other: _____ ICD 10: _____

## 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

**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
- ☐ Coronary or other arterial revascularization
- ☐ Stroke
- ☐ Transient ischemic attach (TIA)
- ☐ Peripheral arterial disease (PAD)
- ☐ Other: _____

☐ **Patient currently on maximally tolerated stain 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 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: _____

## 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:** (Check all that apply)
☐ Epinephrine 0.3mg IM as needed
☐ Diphenhydramine _____ mg PO as needed
☐ Solu-cortef 250mg-500mg IV infusion as needed
☐ NS Hydration 500 ml IV infusion over 30 minutes as needed
☐ Solu-Medrol 40-60mg via IM injection 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 | NONE |
| | ☐ **Maintenance**: 284mg SC injection every 6 months | _____ |
| ☐ 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** **Print Name** **Date**
**Dispense as Written**

**Prescriber's Signature** **Print Name** **Date**
**Substitution Permitted**

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ACHC ACCREDITED
ACCREDITED Compounding Pharmacy