LEQVIO® Referral Form

Fax Completed Form To: **Phone:**

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	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 40-60mg via IM injection as needed
	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	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**	**Prescriber's Signature**	**Print Name**	**Date**
Dispense as Written			**Substitution Permitted**		

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