





## **Fax Completed Form To:**

## **Phone:**

		PATIENT II	NFORMATION				
Patient Name:		Referral Date:					
Address:			City/State/Zip:				
Home Phone:			Work Phone:				
Secondary Contact:	Height: V		Weight:	eight:			
Allergies:							
PROVIDER INFORMATION PROVIDER INFORMATION							
Physician Name:		Lic.#:		DEA#:			
Practice Name:			NPI#:				
Address:		City/State/Zip:					
Office Contact:		Fax:					
Supervisory Physician (if applicable):							
DIAGNOSIS							
ICD 10 Code	Atherosclerotic heart disease (ASVD)	SVD), IC 10: I25.10					
Required	☐ Familial Hypercholesterolemia (HeF	H), 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         For ASCVD:         ☐ History of clinical atherosclerotic cardiovascular disease includes one or more of the following:         ☐ ASCVD score       ☐ Coronary or other arterial revascularization         ☐ Acute coronary syndrome       ☐ Stroke         ☐ Coronary artery disease (CAD)       ☐ Transient ischemic attach (TIA)         ☐ History of myocardial infarction (MI)       ☐ Peripheral arterial disease (PAD)         ☐ Stable or unstable angina       ☐ 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:				
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) ☐ Diphenhydraminemg PO as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other							
Supply Orders: All sup	plies as appropriate to therapy will be provic	led as necessary.					
PRODUCT PRESCRIPTION INFORMATION REFILLS							
Is this a first dose?	his a first dose?						
☐ LEQVIO						NONE	
	☐ Maintenance: 284mg SC injection every 6 months						
☐ OTHER							
By signing this form an	d utilizing our services, you are authorizin	ng Amerita, Inc. to serve as your	prior authorization des	ignated agent in dealin	ng with medical and prescrip	otion insurance companies.	
Prescriber's Signature Dispense as Written	Print Name	Date	Prescriber's Signa Substitution Perr		Print Name	Date	





