LEQVIO® Referral Form

Fax Completed Form To: 877-418-4495 Phone: 877-418-4114

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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