

LEQVIO® Referral Form

Fax Completed Form To:**Phone:**

Amerita
YOUR INFUSION ADVOCATE

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		Referral Date:	
Home Phone:		City/State/Zip:	
Cell Phone:		Work Phone:	
Secondary Contact:		☐ Male ☐ Female	
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
Office Contact:		City/State/Zip:	
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 ☐ Coronary or other arterial revascularization ☐ Stroke ☐ Transient ischemic attack (TIA) ☐ Peripheral arterial disease (PAD) ☐ Other: _____		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: ☐ 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		NONE
	☐ Maintenance: 284mg SC injection every 6 months <i>Also FDA approved for Homozygous Familial Hypercholesterolemia (HoFH)</i>		_____
☐ OTHER			_____
By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider 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 _____